# NAMI Ask the Expert
# The AAP and AFSP Blueprint for Youth Suicide Prevention: Opportunities to Support Youth and Families

Featuring: **Lisa Horowitz**, NIMH ; **Christine Yu Moutier**, AFSP ; Tamar Taro, AAP

June 9, 2022

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**Dan Gillison** (00:00:00):

Thank you very much, Teri, and good afternoon and good midday to our West Coast participants. We're so happy to have you with us on today. On behalf of our board president, Shirley Holloway, our board members, our state organizations and affiliates, all our volunteers and our staff, we thank you for joining us today and you making the time to be here for NAMI Ask the Expert, the AAP and AFSP blueprint for youth suicide prevention opportunities to support youth and families. And we will introduce our experts in just a second and really do value the time that you're giving us on today. **Lisa Horowitz**, **Christine Yu Moutier**, and **Tamar Haro** are with us, and we'll tell you a little bit about them in just a second. So let's move on to the next slide.

We want to say something to you at the very beginning of this. If you need support while hearing a story today or any time, remember, you're not alone and consider reaching out to our helpline, which is at 1-800-950-NAMI or 6264 or info@nami.org or visit NAMI.org/help. So just remember that as we go along on today's presentation. Next slide, please.

So we talked about our experts, ask the experts. So we have Dr. **Lisa Horowitz** with us. She is a senior associate scientist and pediatric psychologist with the Intramural Research Program at NIMH. Dr. Christine Moutier, who is the chief medical officer for the American Foundation for Suicide Prevention and **Tamar Haro**, who is the senior director of federal and state advocacy for the American Academy of Pediatrics. So welcome to our experts. We do appreciate you being with us on today and with no further ado, let me mention this at the very beginning.

You see on this slide that we talk about the fact that this is an information webinar series, and it's not intended to provide medical advice on any specific topic or for any specific individual. This is an overview, and we will take dives in different directions to give you critical information that can help you be the best in the communities that you serve. And to all of you that volunteer in communities across the country, thank you for that. With that, I'd like to introduce to you our first expert, Dr. **Lisa Horowitz**. Lisa?

**Lisa Horowitz** (00:02:29):

Thank you so much. It's such a privilege to be here and to be presenting to all of you who I really think every single one of us could really make a difference in reducing suicide. Before I get started, because I work for the government, I need to put this slide up that says these are my views and I have no financial conflicts disclosed. And I just want to start off by saying if I was there in person, I would ask for a show of hands for anyone whose lives have been touched by suicide. And although suicide's a relatively rare event, the ripples effects are endless and almost every hand in the audience goes up, so I just wanted to start off with my condolences to anyone who's lost someone to suicide. Sorry, this is... okay.

**Lisa Horowitz**:

So just a little bit of a very brief background on suicide. It is the second leading cause of death for youth aged 10 to 24. And if you look from 2019, actually, if you look at the total amount of deaths by [inaudible 00:03:43]. Young people are not supposed to die. They're supposed to grow up and live long, healthy lives. But if you look at the total number of deaths, 20% of those deaths were from something that is potentially preventable like suicide. So that, I think, is just a staggering number. And then if you look at this graph over time, you'll see the suicide rate, and we did have a very small dip in 2019, and I'm afraid to report that in 2020 for young people, it's going back to up.

I'm sorry, I'm having trouble advancing my slides. Are they advancing for you? Okay.

So just to show you just a little bit about this change in time. In 2007, if I was presenting to you, I would've said it was the 11th leading cause of death for 10- to 19-year-olds, and that there were more deaths from suicide than two other leading medical causes combined. But now... I apologize, I'm having trouble... okay. But now in 2018, it's the 10th leading cause of death and for all ages, but the second leading cause of death for youth, and more kids die of suicide than these 20 other leading medical causes combined. So a problem that is getting worse.

So there's also significant racial disparities in suicide rates and by not only by race, but by sexual orientation and gender identity and the disparities don't stem from the identities on their own. They really reflect inequities and some barriers to access and things like that. So this is a really important thing and something important we learned while we were creating the blueprint, especially,

You know what? I might ask you to run my slides because I don't want this to be distracting that they're... for some reason, I'm not able to run them like I was in practice. Is that okay if I ask you, Teri, to take them back or Jordan? [inaudible 00:06:15].

**Teri Brister (00:06:15):**

Yes, yes, yes, yes, yes, I've gotcha.

**Lisa Horowitz** (00:06:16):

Okay, great. Thank you. And if you go back one. So there are... I just wanted to show this graph and the American Indians, Alaska natives are that represented by that black line, and you can see they're outliers. And so American Indians, Alaska natives have the highest rate of suicide than any other race or ethnicity, but the steepest increase we're seeing now is with Black youth and next slide, please. And so much so that the Congressional Black Caucus convened an emergency task force. And I encourage everyone to read the Ring the Alarm report because this really calls for more interventions and more research on Black youth and suicide. Next slide, please.

So there are many underserved, understudied populations at risk, not only BIPOC youth, but LGBTQ+ youth, youth with neurodevelopmental disorders like autism, kids in the child welfare system, kids in the juvenile detention centers, and kids in rural areas. And what we are hoping is that universal screening can really... and universal meaning everybody really means everyone gets the same opportunity to be recognized, and it really can help identify underserved and understudied individuals.

Next slide, please. So people are wondering what happened during the pandemic and in the beginning, we didn't really see such an increase, but now, we have some data, and if you look at emergency department visits in February and March of 2021 and you compare them back to 2019, what you find is that there was a 39% increase in young people visiting the ED for suicide attempts. And this is among 12 to 17 year olds and then just look at the difference, even, for females.

**Lisa Horowitz**:

There was a 51% increase for females, 4% for males, and these rates might even be higher in those more at risk loops that I mentioned in the previous slide.

Next slide, please. So what we did was the American Academy of Pediatrics and the American Foundation for Suicide Prevention, along with some experts from the National Institute of Mental Health convened a Youth Suicide Prevention Summit, and that was in three days in February, and we called together clinicians, public health officials, school community organizers, people in research, academia, really a whole host of diverse stakeholders, and our goal was really to develop something called the Blueprint that we're going to talk about today. And we were going to do it in three areas: clinical settings, community school settings, and advocacy.

And once we had this three-day summit, we realized that minoritized youth who are at greater risk for suicide was an issue that we needed to keep discussing, and so we convened another meeting where we talked about that, and then we had a third meeting where we invited federal partners who were working on suicide prevention to also partner with us so that we could come up and gather all this information and create this Blueprint for youth suicide prevention.

Next slide, please.

So the key takeaway from all these meetings is that suicide is often preventable and that we really need to identify and then figure out how to intervene and support youth who are at the highest risk for suicide and that we really needed to address upstream risk and protective factors, right, because we always want early prevention, that's early detection is a good way for prevention and that health equity was crucial and that we needed to create resources in education and then how important partnerships were to all of this.

Next slide, please.

So, yeah, taking information from all these stakeholders and all these meetings, we created this Blueprint for youth suicide prevention, and it's really meant to be a roadmap, a guide for anybody interested in embedding suicide prevention in their work with young people. We created strategies to identify support, people in clinical settings, people in community settings, and how to advocate for suicide prevention. And we invite you all to engage with us on implementation because, right, it takes a village and we all need to do this together.

And that was what was so exciting about these summits was all these organizations were working together. So I'm going to talk about the strategies for the clinical settings.

Next slide, please.

So why do we... so my research, I'm a pediatric psychologist, and I focus on creating suicide risk screening tools for physicians and nurses in the medical setting. And the reason why we think the medical setting is such a great venue to detect kids at risk for suicide is because if you look at death registry studies, the majority of people, and this goes for adults and youth, who have died by suicide have visited a healthcare provider months, sometimes weeks, before they died. Now, the problem is is they don't walk into their doctor's office and say, "I'm thinking of killing myself." So if someone doesn't ask them directly, "Are you thinking of killing yourself," they most likely won't talk about it. So the majority of suicide attemptors go unrecognized because the majority of medical settings do not screen for suicide risk.

Next slide, please.

**Lisa Horowitz:**

So I'm fortunate enough to be part of a research group that said, "Can we save lives by screening for suicide in a medical setting," and we believe the answer to this is absolutely yes. Next slide, please.

So the Blueprint is based on this three-tiered pathway that not only research from my group, but research from other groups has seen that this is what works because what happens sometimes is if hospitals and medical settings start screening for suicide risk, the moment someone mentions suicide, they can be... [inaudible 00:13:01] I'll say misinterpreted, mistreated and maybe put in a paper gown and all their belongings are taken away and then they get a very costly one-to-one sitter, and we don't want this to happen. So we have this pathway that we believe will make screening and management of people who screen positive feasible.

So it starts with a brief screen. And then the most important part of this three-tiered pathway is the brief suicide safety assessment because that determines what happens next with the patient. Do they need a full mental health evaluation? Do they need an outpatient referral or no further action is required at this time? So I'm going to talk a little bit more about that.

Next slide, please.

And it's really important to understand the difference between screening and assessment, right? So screening is a very rapid way to identify someone who needs further evaluation. It's not meant to diagnose. It's not meant to predict. It's meant to say, " This person needs more clinical evaluation." The assessment is the more comprehensive evaluation. It confirms the risk. It guides next steps.

So there's a difference between a screen and an assessment, and those two ideas often get conflated. And so we're going to talk a little bit about that.

Next slide, please.

So one of the most common myths about suicide is that asking people about suicide is going to put the idea in their head. And so a lot of clinicians that I work with worry that the parents are going to have this worry. By asking my child about suicide, you're going to put the idea in their head. Well, the opposite is actually true and you don't have to take my word for it because there's at least four research studies that refute this myth. And in fact, the best way to keep someone from killing themselves is to ask them directly, "Are you thinking of killing yourself" and then listening to the answer and then finding help for them.

Next slide.

So Tier One of the pathway is screening, and it should be a very rapid, only a few questions and they should be evidence-based, something that came from research. Right now, Bright Futures and the AAP is recommending suicide risk screening for all kids ages 12 and above and then kids aged 8 to 11, it could be more targeted screening. So when you see that as clinically indicated, maybe if the child has a behavioral health, chief concern, and then under age 8, there are no screening tools that have been developed through research for kids under 8. So what's more important is to recognize warning signs and then assess the child who's under 8 because there are kids under 8 who are thinking about suicide. Anyone can be trained to screen for suicide risk.

Next slide.

So that's Tier One. This is an example of a... there's many suicide risk screening tools. This is one that my group happened to develop called the ASQ. It takes 20 seconds.

Next slide.

**Lisa Horowitz:**

And I'll show you how it works, and I'm showing this... I know some of you are clinicians and some of you are parents of children who are going to go to medical settings, and so this is an example of a screening tool. In the past few weeks, have you wished you were dead? In the past few weeks, have you felt that you or your family would be better off if you were dead? In the past week, have you been having thoughts about killing yourself and have you ever tried to kill yourself? Very blunt, right? Gets right to the point. Some people are put off. Some parents see this and think, "Oh, I don't want you asking my child about this," but you know what? We did studies where we asked parents and kids about this and the kids are okay. We feel like being direct is important.

Now, we know from research that in the medical setting where the majority of patients are presenting with medical chief complaints, the majority of patients are going to screen negative. So can you click through this? Just to show you an example. What I tell clinicians is that the majority of your screens are going to look like this, and, Terry, if you don't mind clicking real quick through that. They're going to be no's and that's going to be a negative screen.

Now, sometimes, the screen will be positive if someone... the way this is scored is anyone who says yes to questions one through four gets asked question five, "Are you having thoughts of killing yourself right now," and that's an acuity question. So there's two ways to screen positive on the ASQ acute and non-acute and the majority of people who, if you're giving this in a pediatrician's office, the majority of positive screens are going to look like this.

And Terry, you can click through again.

So it would be yes to one or two of the questions, and then you give that question five, and it's a non-acute. So when we looked into hospitals and we looked at big data, a data set with 90,000 patient encounters, 99.5% of the positive screens were non-acute positive. And the reason I emphasize this is because providers get nervous. They think if I give a screen, everybody's going to screen positive and that's not true. It's no longer theoretical. Practices are doing this successfully. And when you identify someone who's at risk, clinicians are glad that they know.

Now, you do have to prepare for that emergency, and that would be, click through, please, Terry, when they say yes, and that's an acute positive. So that is an emergency. That's when full on safety precautions are needed because the person's telling you they're having thoughts of killing themselves right now.

Okay. Next slide, please.

So the ASQ is available in the public domain. It's been tested at inpatient medical surgical unit, outpatient primary care, and specialty clinics. It's been tested with adults now, so hospitals can use one tool, and it's being tested in those areas in black. We're really excited about our Indian health service collaboration because as I told you, American Indians have the highest rate of suicide, and it's translated into over 17 languages.

Next slide, please.

Now people often ask, "Can I use a depression screen to screen for suicide risk?" So what we did was we embedded the PHQ-9, which is a depression screen. It's a really good depression screen. And we embedded that in our validation studies. And what we found was that had you only used the PHQ-9, you would've missed ⅓ of the kids at risk for suicide. And if you only used... PHQ-9 has one item that asks, "Have you wished you were dead or had thoughts of hurting yourself," so it doesn't say killing. And what we found is a lot of people use that ninth item as the suicide risk question. But in our studies, if you screen only with that question, you miss 56% of the kids at risk for suicide.

So the bottom line is you shouldn't make the patient jump through hoops. Don't just screen the patients who screen positive on depression because many people who are at risk for suicide are not depressed. So it should be universal screening, and you should use a suicide risk specific instrument.

Next slide.

So what happens when a patient screens positive? This is most important.

Next slide, please.

And this is what I was saying before that you can't treat every young person who has a thought about suicide like an emergency, and this is when it becomes a problem because this feels very punitive to people who are seeking medical attention, and then they talk about their thoughts of suicide, and then they get put in a paper gown and they get that one-to-one sitter, and often, it's not necessary. Sometimes it is, but often it's not.

And so the Blueprint is meant to give clinicians a guide to avoid this scenario. And so that there needs to be some tolerance for suicidal thoughts, especially chronic suicidal thoughts, and there needs to be able to be a way to discern what's an emergency and what is not an emergency.

Next slide.

So we have follow-ups mentioned in the Blueprint for people who screen positive with a brief suicide risk safety assessment.

Next slide.

And again, this is the second tier of that inverted triangle. This is meant to help the clinician say, "Is this imminent risk? Is further evaluation needed or no further evaluation is needed at this time?" And this is what makes or breaks the screening program is not going from the screening tool to disposition, but having this middle step.

Next slide, please.

So the Blueprint also mentions interventions that clinicians can do because a lot of clinicians, when we talk about this, say, "You know what? I have no access to mental healthcare to give my patients, so I don't want to screen because I don't have anything to offer them," and then we always say, "Look, the child is thinking about this whether you screen them or not." And there are things you can do in your office. You can do safety planning where you help the child come up with coping strategies for what if it's 2:00 in the morning and they're thinking about suicide, or you do lethal mean safety counseling. How do you safely store or remove lethal means from the house? And you give them the Suicide Prevention Lifeline and the Crisis Text Line, and those are four things you can do in your office.

Next slide.

So the Blueprint also helps clinicians prepare their practice by identifying a team of champions, by making sure leadership is on board, connecting with community mental health clinicians. And then what's most important is the Blueprint is not rigid. It's meant to be a guide, and it's meant to be nuanced to fit each setting and training is so important.

Next slide, please.

It also talks about considerations for caring for patients once they screen and how to prepare your clinic, how to launch the program, and then how to prepare your clinic in the event that one of the patients does die by suicide.

Next slide.

So this is my pep talk slide to the clinicians. You can do it. I empower every parent out there to urge your pediatrician to do this because every adult that works with youth can help save a life.

Thanks so much.

**Christine Yu Moutier** (00:23:58):

Thank you, Lisa. I think I'm up. So it's great to be here with...

**Christine Yu Moutier** (00:24:00):

I think I'm up. So it's great to be here with the NAMI community and a huge thanks and shout out to the NAMI leadership team that are just doing such important work with you all and have provided such amazing resources over longstanding for communities. And we at AFSP are gratified to work with NAMI in so many different ways, including in today's SE expert webinar. So I'd like to share the part of the blueprint for youth suicide prevention that relates to community suicide prevention efforts that we feel are either evidence based or evidence informed. Evidence based meaning there's actually data to show that program or that approach has been evaluated and shows reductions in suicidal behavior. And evidence informed means there's every reason to believe that it would be effective, but it hasn't been studied well yet.

So both are being utilized. And maybe even before I get into it, I'd like to just say that of the many, many incredible opportunities I've been privileged to be a part of in the national work of preventing suicide, this last decade, in my role at AFSP as chief medical officer, this partnership with the American Academy of Pediatrics, with the expertise of Dr. Horowitz and others from NIMH has been one of the most remarkable. Because number one, the field of pediatrics said they wanted to be equipped with the ability to help their young patients better when it comes to mental health needs and to prevent suicide and to develop some tools in their practice and to have their clinical teams know what to do. And so that sense of need and ownership by the field of pediatrics.

I've never seen it at that level before within any primary care field of clinical practice. And so it's a big shout out to AAP for taking it on as a priority and really developing this resource for pediatricians. Now, as Lisa explained, Dr. Horowitz from IMH explained the process of developing the blueprint was not only to focus on pediatricians in their clinical role. It was also to take a look at what is happening in the community setting and what role can pediatricians play in engaging with community based partnerships. And after I present my part, you're going to hear from the lead person at AAP who leads their policy efforts in the advocacy section which is the third part of the blueprint, which by the way, NIMH did not play a role in that policy section of the blueprint.

So let me go ahead and get into this. And I have a feeling that this group of you all here today, who are attending this webinar may interested in both, well, really in all three settings are all three applications in terms of suicide prevention. Clinical, community based, as well as policy. The community arena is one that all of us live in, regardless of the professional hats we wear. And so I'm really excited to get into the blueprints resources around community and school based suicide prevention. So go ahead, Terry, next slide. So to just ground us in why we're talking about school based, workplace based, faith organization based, suicide prevention efforts, I just want to remind everybody that we have an important public health framework that we can all operate within that tells us that when you make an investment as a nation, let's say that, in a particular leading cause of death or a particular health outcome, and an investment means investing in the research to understand what drives it and what constitutes effective prevention and intervention or treatment.

**Christine Yu Moutier**:

And also what supports recovery. That now that we have the science to understand that suicide while complex, and certainly multifaceted in terms of the drivers of suicide risk, it's never one thing, it's always multiple things. But now that we understand that even while complex suicide is a health outcome or a health behavior in all of that complexity. We can understand suicide prevention within this public health framework, which says we need to have a universal approach that educates the whole population. And then we need to also do some more selective and targeted strategies even before we get to treatment interventions and supporting recovery. So the community based part of the blueprint is really more in the universal and selective section of this public health model. Next slide.

And when I think about how do we know what constitutes evidence informed suicide prevention strategies, especially at the community level, but the clinical setting as well, for that matter, we have to rely on research and then we have to gather up all of the research experts, the clinical experts, and the community experts, as well as all of the key voices of lived experience, loss, and people in the community who leave youth groups, or who are involved in education or athletics for youth. And all of those types of people were part and parcel to informing the blueprint. And that was also another reason that it was one of the most amazing experiences to be part of, to be able to be that inclusive and really actually to listen to every single voice of input. I can tell you that over a hundred organizations and individuals reviewed the drafts of the blueprint, and we took every recommendation unless it was way outside of evidence informed practice.

And so summing up the concepts in terms of what constitutes effective suicide prevention, especially at the community level. What I'm showing you here is a consensus driven group of practices that are based on the CDCs technical package on suicide prevention, the IMH research, SAMSA's best practices, we at AFSP have our own consensus as well. And this is a combination of all of those. And so what this tells us is that anything for a population I'm talking about, more so than an individual, anything for a population that increases access to mental healthcare and substance use programs, especially those that are effective and culturally appropriate and evidence based is going to have the potential to drive down suicide rates for a population. And in fact, research has shown that anything that increases interpersonal connectedness and that's many, many different community and school based and faith organization based efforts, anything that reduces access to lethal means can reduce suicide risk.

And what I always say is that if you're going to do just one thing and suicide prevention always needs to be about more than just one thing. But if my neighbor comes to me and says I have someone in my home, my child, my spouse whomever in my home who is struggling right now, and who might be thinking about suicide, or they've told me that they're thinking about suicide, the first thing I say to them is let's help make your home safe from lethal means. And what that means is gathering up any firearms, toxic substances, bleach, medications, et cetera, and getting it secured ideally outside of the home. But certainly, if that's not possible to have it truly secured within the home. And the second thing I always say is to open up a caring, supportive dialogue, where the person who is potentially at risk is afforded the opportunity to speak as freely as they will allow themselves to.

But remember it requires an invitation just like Dr. Horowitz said, oftentimes, youth who are experiencing suicidal thoughts, do not share it spontaneously with their parents, with their teachers, with their pediatricians, and actually studies show they're more likely to share it with a peer. So anyway, I'm digressing a little bit, but any strategy that enhances coping and problem-solving skills, resilience building, and so efforts even in elementary school level that are not having to go into suicide education directly to those children, but that enhance their sense of self-efficacy and their own social and emotional learning.

**Christine Yu Moutier**:

Those things can actually show results. 10, 15 years later, I'm thinking of something called the good behavior game in schools, but there are other programs as well that have shown those positive outcomes. We do need to be able to identify youth who are at risk and struggling, and remember suicide risk is dynamic.

It's not a concrete thing. So it changes over time. And that's one of the reasons that routine universal screening for suicide risk in pediatric settings is so very important. A focus on equity and lived experience, we need to always be including that lens. Some attention to the environment and economic supports and educating parents and family members, and in fact, that is something that if there's interest, we can talk about more in terms of education that is available for family members, for parents. If there is a youth who has survived a suicide attempt, or who is currently struggling, that kind of education is actually hard to find and it's really, really important because even with all of these grounding principles and with myself trained as a psychiatrist, and then with my deep involvement in suicide prevention, having walked that walk before with my own family members, I can tell you that it's a different matter living through the moment to moment of what to do and how to support them and how to not overreact, and if they're refusing help and all of those nuances.

And I will just say that NAMI's new book, You Are Not Alone, has a chapter that is devoted to some of these very concepts as well. We also say that postvention is prevention in the suicide prevention field. And that is because after a suicide has occurred, there's a very important key moment where postvention efforts can allow healthy grieving of the community and can potentially mitigate risk of suicide contagion, thereby reducing the suicide risk of those vulnerable individuals who have just been exposed to another suicide risk. And there's a second prong to this, which is that schools and workplaces healthcare settings sometimes are moved after a suicide has occurred to engage more fully in their suicide prevention efforts. And so for a number of reasons, we say postvention is a form of prevention. Next slide. Okay. So I'm going to speed up and just cover some of the things that are in the blueprint.

There are a plethora of really practical tips related to community engagement in suicide prevention. And so for anyone who hasn't gone on to the AAP website to check out the blueprint, the URL is right there, www.aap.org forward slash suicide prevention. And I would really encourage you to kind of just take some time on your own and go onto the website. We developed it in, of course, document form, but now it's beautifully presented in this more interactive format. But what that also means is it's not linear so you can really explore around and find these really practical tips that relate to suicide prevention in all of these different settings that we're talking about. Next slide.

Now, a word on what we mean when we say that equity is a critical part of suicide prevention efforts. So I think, gosh, this is a big topic, but I'll just say a couple of things. What we know is that it is not an individual's identity on its own, whether we're talking race, ethnicity, sexual orientation, or gender identity, that on its own increases risk of suicide. It is the experience of living in the real life world that has just still fraught with structural inequities, racism, and discrimination for a number of different populations. And it's that experience that increases risk through a number of different means. You know, when a child is developing and their brain is developing and their sense of identity is forming and their experiencing these microaggressions or overt discriminatory experiences, or LGBT youth with rejection in the home or in the school environment or elsewhere, all of those can change the course of their psychological and their neurological development to increase risk for suicide.

**Christine Yu Moutier**:

And all hope is not lost because there are things that we can do to rectify those situations, to identify those who are at risk, and to make sure that when we're going into schools or we're presenting on mental health or suicide prevention education in various community settings, that we're taking every opportunity possible to use concrete examples of how certain populations like Black youth or Latinx youth or LGBT youth have been bearing the brunt of discriminatory experiences that actually research has shown led to phenomenon such as the school to prison pipeline, which means that Black, especially males who are suffering from mental health conditions are more likely to be miscategorized and misconstrued as requiring a disciplinary approach that leads down a path to this outcome that never gets them the help that they actually need. And it's of course a very complex situation, but we have to develop that level of understanding and nuance.

If we're going to move things forward and create improvements in these inequities. Next slide. Now there are a number of natural groups and champions that can fairly readily engage in suicide prevention efforts. And so we're talking about educational settings, whether it's K12 schools or higher education, community, faith, and parent organizations, sports, athletics, scouts, certainly medical professional associations are well poised because they're a trusted resource. That's one thing about our blueprint is that pediatricians are trusted resources in their communities who can help initiate these suicide prevention efforts in these other community settings, juvenile justice, child welfare, and then of course, policy makers.

So these are all natural champions. And I would say it's a journey for them. They're not trained, they're not mental health professionals, and they don't need to be, but one step at a time they can do things like get their whole staff trained on some basics around mental health and suicide prevention and know their local resources and start putting into place, for example, in schools, a policy and then training their staff so that there's an actual safety net that gets developed around at risk youth. Next slide. Now, when we go and set out to explore a potential partnership, whether it's between two organizations or two individuals, for that matter, we can think about just conceptual strategies. Think about who are the key partners that might be missing in your community related to suicide prevention. So understand what that landscape is and who have been involved, who have been the organizations or individuals leading effective suicide prevention efforts, try not to reinvent the wheel, but come alongside and compliment. Certainly find shared goals with that other entity so that you establish what are our shared goals together in this partnership.

Consider the relative strengths and where you might compliment each other in the reasons for forming that partnership and define success so that you have some measurable, ideally, some metrics that you can show for the partnership, which of course, goes a long way towards establishing trust with the community. If there's a donor situation involved, they're going to need those metrics. And they also actually allow you to tweak your approach in real time, if you're getting constant feedback along the way, next slide.

So there are a number of again, community and school resources that are organized within the blueprint and this little box shows you an example of some of the resources and programs. And we organize them by evidence based programs for suicide prevention, which is a very stiff criteria. Again, it means that those organizations or programs have actually shown outcomes from the program that are promising or show actual reductions in suicidal behavior. And then we have a much longer list of evidence informed. So they're all vetted resources that are in the blueprint, but they're sort of two different standards and they're categories that way. Next slide.

**Christine Yu Moutier**:

I'm going to close here just showing you a couple of examples of resources that are included in the blueprint. I mentioned that schools can implement suicide prevention policies and train their staff on those policies as well as really involve the parent community and also have direct involvement in education with the students, depending on the age. Suicide prevention education does look quite different for the different age groups, of course. We also have a postvention guide called after a suicide toolkit for schools that has actually been customized to other settings as well. It's been such a solid and well received resource that is much, much needed because in that moment after a suicide, it is a crisis moment. And so it's really a crisis response toolkit for how the leadership can convene. And there are templates for email communications, verbal communications, interacting with the media and so forth. Next slide.

We also included a template letter in the blueprint that anyone, but certainly, a parent or a pediatrician or a coach, really anyone, can use to write a letter to the editor in a timely moment, might want to say something about the need for the community to engage in youth suicide prevention and to provide some resources to do that. This template letter could also be used as an advocacy message to reach out to a local policymaker to express your voice in prioritizing suicide prevention for youth in their local jurisdiction. Next slide. And with that, I will close my part and turn it over to Tamar Haro from AAP.

**Tamar Haro** (00:45:23):

Well, thank you so much, Christine, for the terrific presentation and to Dr. Horowitz before her and a huge thank you to NAMI and its leadership for organizing this convening and for being a national leader here. And lastly, thank you all for who are on the line for taking time to be a part of this conversation. I'm very excited to be the final speaker here. As was mentioned, I work at the American Academy of Pediatrics and we were very honored to be one of the co-authors of the blueprint. And my role at the academy is on the advocacy team. And I work day in and day out with lawmakers on Capitol Hill and with our chapters at the state level, as well as folks in the Biden administration to advance a mental health for children and adolescence. And so I also get to do a lot of training of in advocacy.

So I very much look forward to the Q&A discussion. My role today is really to talk about the policy and advocacy recommendations of the blueprint. I want to just reiterate a point that Christine made earlier, which is that the advocacy and policy recommendations in the blueprint were developed by our two organizations, by AAP and AFSP, the National Institute on Mental Illness and Mental Health was not part of that development of the advocacy section. And anything that I cover here in terms of recommendations does not necessarily reflect the views of NIMH, the NIH or the department of health and human services, or the US government more broadly. So I just wanted to make sure that we had a level understanding of that. So if you could go to the next slide.

So as you've heard from multiple times today, suicide is complex and tragic, and importantly, it is also preventable. And so I'm going to talk in my portion of the conversation today about some of the advocacy and policy approaches which are really a critical adjunct to the clinical and community suicide prevention strategies that you've heard described today. The blueprint really outlines key advocacy priorities that will help identify and support youth at immediate risk for suicide. Address upstream factors, risk and protective factors, and promote equitable access to health and healthcare. It also identifies key...

**Tamar Haro** (00:48:00):

And healthcare. It also identifies key policy priorities that can be implemented at the local state and federal level. So next slide. So our first key priority is to build the evidence base to address the disparities that we know exist in youth suicide prevention. And there's some really specific and concrete actions that could be taken here. First is to support increased funding for culturally informed suicide prevention research to identify and address risk and protective factors. Also to understand cultural views of mental health and help seeking. To develop, adapt, and validate clinical tools and pathways for diverse cultures. To understand the impact of racism, discrimination and intergenerational trauma. And to understand and address barriers to mental health treatment. And importantly, we need to promote diversity in suicide prevention research, placing the population of focus at the center of research design and requiring that research studies include diverse populations in their sampling. Next slide.

And another key priority here is ensuring access to affordable and effective care for all youth. And I think this is really important because care that is not accessible, care that is unaffordable for a child or family is care that's inaccessible. So some specific policy actions that the blueprint identifies is increasing funding and resources for youth access to mental health support, where they are, so in their communities and in schools. Promoting innovative care models like the very important telehealth and tele consultation models that many states are receiving federal funding through HRSA to expand. Providing support to pediatric primary care settings by mental health teams so that pediatricians, family medicine are better able to provide those services in the primary care settings when children are already there seeking medical care. And then of course, collaborative integrated care models. And we need to strengthen linkages between serving systems, no one system.

Children of course touch many, many different systems. And so all of those are touch points and opportunities to really strengthen linkages and increase access to services, whether that's in a health system, a school, social services and community organizations. And importantly, for children who are accessing multiple systems, whether it be the child welfare system, for instance, these are all important areas for policy intervention and ensuring that access is achievable. And quite importantly, we need to promote diversity, equity, and inclusion in mental and behavioral healthcare. And I'm going to talk a little bit more about that in a moment. But we have to recognize that there's been a disproportionate impact on children of color during the COVID 19 pandemic. And racism itself has an impact on the mental health of children of color. So our solutions here and our policy interventions need to put equitable solutions first. Next slide. And then another key priority here in the blueprint is around payment and insurance coverage, which has been identified by many stakeholders as a persistent and major barrier to access to care. Care that is not paid for is often inaccessible for families because providers find it unsustainable to be able to provide the care they want or integrate the services they want into their practices because of the barriers to payment and to integrating services in a primary care setting. So that includes everything from supporting the actual provider payment for mental health and suicide prevention services, no matter who that provider is. Incentivizing screening, follow up and collaborative and integrated care models for mental health support. And then preserving and extending insurance coverage for pediatric mental and behavioral health services. And I'm really happy to say that thanks to NAMI, thanks to AFSP, and so many other stakeholders, we're making a lot of progress in this regard. But we have a lot of work to do. Next slide.

And critically important in the blueprint and in the overall advocacy for suicide prevention is really building the mental and behavioral health workforce. The blueprint calls for the development of a national strategy to expand the diversity supply and distribution of the mental and behavioral health workforce. And I think that's critically important. It also calls for the support for loan repayment assistance for pediatric and mental health professionals.

**Tamar Haro:**

Across pediatrics and mental behavioral health we need to increase provider capacity, competence, and compensation in addressing mental health needs. And that's going to be achieved through many ways. It's going to involve increased training opportunities, licensing, addressing licensing barriers. Building up the curriculum for mental health competencies and suicide prevention training, and importantly anti-biased training as well as ensuring that we have culturally and linguistically appropriate care. Next slide.

And just to underscore a point that Christine made earlier, we have to address the lethal means access to reduce suicide risk. That means supporting clinicians in screening for lethal means access and providing safety counseling, increasing funding for research related to firearms and suicide prevention, promoting policies to restrict access to lethal means like voluntary firearm removals or something akin to the prescription drug take back days, and promoting extreme risk prevention orders or red flag laws, which we're seeing in a lot of states. And these are laws that allow families, friends to petition a judge to remove firearms from a person at risk of hurting themselves or others. Next slide.

And then another key priority is to address disparities in suicide risk. And I talked about this a little bit earlier. And that has to happen in a number of ways, including through education and ultimately through policy change. Here, we're talking about educating clinicians, policy makers, and the public on disparities that exist in suicide risk for different populations. Importantly, we need to support policies that eliminate systemic racism and discrimination. And to promote enhanced suicide prevention and mental health resources for schools and promote suicide screening and mental health services in juvenile justice settings, the child welfare system, and other systems of care. And lastly, we need to provide adequate funding for culturally and linguistically informed suicide prevention programs, is a critical component to fulfilling this policy recommendation. Next slide.

Another key priority is fostering healthy mental development in children and adolescents. And I think this really starts as early as possible in policy and is often overlooked when the focus importantly has been on crisis intervention and children with serious emotional disturbance. But this recommendation is really talking about building a culture of health and healthy mental development in our children and adolescents. And it's going to take sustained advocacy to shift the focus and to ensure that our funding systems and our funding mechanisms reach the full continuum of care and continuum of services that children need. And in this regard, we really would encourage funding and resources for evidence based and evidence informed programs to foster resilience and healthy mental development. Supporting policies and programs to address underlying risk factors that impact suicide. And then lastly, encouraging integration of strengths based and trauma informed care into clinical and school settings. And this is going to take a lot, as I mentioned, a lot of sustained advocacy and a shift in the focus and prioritization that has existed for many years, particularly through existing federal funding mechanisms. Next slide.

And finally, as I talked about the sort of continuum of care and how the blueprint recommendations really address the full continuum. That continuum has to include support for children and adolescents in crisis. And here we're talking about increasing funding for suicide prevention, specifically across the continuum from primary care and subspecialty care settings, emergency departments and inpatient units, mobile mental health crisis intervention, and follow up care, and then community and school based care. Support policies to improve our national crisis response infrastructure. And we are really at an inflection point here with the implementation of the nationwide 988, mental health crisis line coming online, boy, next month now. We're already in June.

**Tamar Haro:**

So this is a really key moment in time to be getting ready for that and to ensuring that the system is adequately prepared in the field for the needs of children and adolescents who would take advantage of the 988 line.

And that's going to require a new training, behavioral health training, for crisis response teams. We don't do well by children when we simply translate a system that exists for adults and just assume it's going to work for children and adolescents. They experience the world differently. It is much more likely that the folks calling this line may be friends, may be family members. Children spend a majority of their days away from their parents, whether they're in school or camp or childcare, you name it, after school programs. So we really have to ensure that the system for crisis intervention is designed with the needs of children and adolescents in mind. And it also will require crisis training for first responders who really are in a very tough spot. And we have to ensure that they have the proper training for meeting the needs of children and adolescents, and of course support it. And it all comes down to funding at the end of the day. And so ensuring that we have a well funded system is going to be critically important.

So before I go to the closing slide, I do just want to say I really feel like we are at a moment of incredible opportunity. There's a tremendous amount of will and desire and forward momentum, both on Capitol Hill, but also within our federal agencies. And so the opportunity right now I think is a place we haven't been in a while. And so I look forward to the discussion and thinking about how best to leverage your voices as advocates, as parents, as affected individuals, and clinicians, and providers to really take best advantage of this moment in time that we have with federal state and local lawmakers. And then the next slide.

And then just in closing, just wanted to make sure once again, that folks know how to access the blueprint. The web link is here so if you aren't familiar with it, please do visit, take a look at the blueprint itself. There are a lot of resources, including ones related to the advocacy topics that I talked about for advocacy and policy. So with that, I will turn it back over to our hosts. And thank you again so much for having me and my fellow panelists here today.

**Dan Gillison** (01:00:46):

Tamar, thank you so very much to you, to Christine, and Lisa. We appreciate what you've shared. And now what we'd love to do is open it up to Q and A. And I have some questions that have been sent to me. There's others that are in the chat, and we are going to try and get to a few of those. The way we've categorized the questions, we've categorized a few under treatment, suicide prevention, and the other category is schools. That seem to have been the biggest part of the questions in terms of segmenting them. So we'll go to those. I think that as you mentioned about advocating, and what all of you have talked about is that it's going to take all of us. So we have to create this quilt and these partnerships and community is very much a part of that. And we so much appreciate this community that we are right here.

So with that said, let me go to one of the questions. This is under suicide prevention, from the studies of those who have attempted suicide, what was lacking that could have assisted or prevented? Aren't their usual signs? Christine.

**Christine Yu Moutier** (01:02:00):

Sure. I can kick us off. And then Dr. Horowitz probably has some thoughts too.

**Dan Gillison** (01:02:04):

Please.

**Christine Yu Moutier** (01:02:05):

So yes, there are oftentimes warning signs that are present when mental health is deteriorating and when a person is becoming suicidal. And so that is where I would put that level one universal education piece that needs to get stigma out of the way. We need to educate parents and people in general about how much we've been dismissing warning signs as normal responses to stress. And it is normal to struggle. This is the thing as a human being, but it doesn't mean we don't do something about it. And so that level of really teaching warning signs and actions to take to everyone in the population is a really important step that I think we're getting better at, but is still not universally being done well. And I think this is a tricky topic in a way, because when a family member has died by suicide, in the immediate aftermath, it's oftentimes the experience that it happened completely out of the blue and without warning. Sometimes. But sometimes family members are fully aware and the person's been in treatment and they've already had an attempt and they've been suicidal. So it ranges.

But oftentimes I've noticed what happens in the loss survivor's experience is that over time, and as they become more educated about suicide, they start looking back and re categorizing some memories of experiences. And of course the challenging thing is that loss survivors oftentimes get into the question of why and the what if. And so I think we want to be very, very careful here. Because on the one hand, we can do much more as a society, but we never want to have the sense be that because we're talking about suicide prevention, that every instance of suicide can be prevented. That may not be the case, because if we understand that it's a health outcome, there are many treatable health conditions that still will tragically end in death. But it doesn't mean that we don't want to do everything we can upstream as well as in the moment of risk. So I know it's a very, very tricky concept, but research is shedding light on lots of missed opportunities. And maybe I'll pass it over to Dr. Horowitz for her comments as well.

**Lisa Horowitz** (01:04:43):

Yeah. Thank you. I think you covered a lot of that very well. I think some of the things we see is what you said, especially maybe with younger children. Sometimes they talk about it. And like for example, I know in a study that I was part of where we looked at kids under 12, a third of the children had told an adult that they were thinking of killing themselves. But I think there's a lot of ... First of all, I can't think of anything scarier than to hear that from your child. But often that talk is not taken seriously. And this is with all due respect to everything you just said, Dr. Moutier. But I think there are some signs. And I think parents also, the research shows that the majority of suicide attempts go unknown to parents.

It has nothing to do with not being a parent who pays attention or not being a good parent. It's actually, the majority of parents don't know about their children's suicide attempts or their children's suicidal thoughts. And that's because kids are very secretive about this. And so that is one of the reason, one of the impetus behind asking the clinicians to ask it at clinical visits. Pediatricians, can you screen this child for suicide because their parent might not know? And that's often the majority of parents. So if another trusted adult asks, they might be more apt to talk about it.

**Dan Gillison** (01:06:25):

Thank you, Lisa. I want to build on that in terms of this, in terms of the screening. This question is a statement and a question. I'm a small group leader in a support program. We have a confidentiality statement that excludes if they share about harming themselves or others.

**Dan Gillison:**

Do you have recommendations about how to screen or open a conversation about this in a non-professional but safe environment?

**Lisa Horowitz** (01:06:53):

Yeah. It's such a good question. I have my own thoughts about confidentiality around this. And I've talked to a lot of pediatricians, and I am not in favor of before screening or before talking to a child saying, "Listen, I'm going to ask you a question about suicide. And if you say yes, that you're thinking of hurting yourself, I'm going to tell your parents. And I'm going to tell this person and this person and this person." I think that's very off putting, but very tricky. However, because we don't do that for other things. Before you take a child's blood pressure, you don't say, "I'm going to take your blood pressure now. If you have a skyrocketing blood pressure, then you're going to have to see the cardiologist and I'm going to take you the emergency department." We don't want to scare the children before we talk to them about it. And it should just be part of conversation in keeping a child safe. In the same way you wouldn't want them to run in front of traffic. It's part of a conversation.

So when you're in a non-professional situation, like maybe a group, you probably don't have to screen with an instrument. You probably can just have the conversation that there's a lot of kids struggling. And sometimes when kids struggle, they think about killing themselves. Is anybody here ever have that thought? I'm just giving an example of how to open a conversation. A lot of times parents will ask me, "Should I use a screening tool with my child?" And I will say, "No." For example, you don't need the ask, because you have the advantage of being able to have a conversation. And it's a very awkward conversation to start. It's a very difficult conversation to have. But I'm going to actually put a link to a video that's very good in the chat, that the Mayo clinic put out. But the screening tools are a way for professionals to start a conversation. If you are not a professional that's seeing the child in that capacity, then you can just start the conversation. Does that make sense?

**Dan Gillison** (01:09:05):

It does very much so. Tamar, I'd like to come to you with a different question. Advocacy, as you were talking about the advocacy, and thank you very much in speaking about NAMI. What can we do more of and how do we do it well in terms of really supporting this area and this critical need coming out of COVID with our young people?

**Tamar Haro** (01:09:29):

Oh, well, thank you for that question. I think our job as advocates for children and families is to keep up the sense of urgency to not let policy makers end their sessions without having acted here for children, whether that's at the federal level or at the state level. So our job, I think, as advocates, and NAMI, and AFSP, and AP, we do this so well, which is to really define the problem and impress upon policy makers a sense of urgency that they must act. And they must in this case act for children. I think there's a lot right now, I mentioned this sort of really pivotal moment in the calendar year with us getting ready for 988 implementation. I think I saw a question come in about that. Now's a really good time to be talking to your governor's offices and asking questions about how they're getting ready.

I always advocate don't go at this alone. And I think that was part of Christine's message too, which is really think about who your allies are at the state level. And go in together, really build that coalition of advocates. Contact your state chapter for the AP, ask them to partner with you. And to really ask some questions about how the state is getting ... there are some things that the states need to do and certainly many things the federal government needs to do.

**Tamar Haro:**

The federal government is provided on states, a lot of resources to date. Probably not sufficient, and so now is a really good time to be asking questions of your state governors and doing that in partnership with your key allies. And really doing a landscape of thinking about who are your allies around the table in the states. The school's another really important stakeholder here. And the other provider communities, whether it's psychology, psychiatry, child psychiatry, to really build that tent. 988 is a key moment in time right now. But to build that out for all the future work that needs to go on beyond 988.

**Dan Gillison** (01:11:30):

Thank you Tamar. And as we talk about 988, we've built a platform called reimagine crisis response. And that operative word reimagine is so critically important. The other part of that is so critically important when you talk about equity and you talk about young adults and youth, is making sure that young adults are at the table in communities across the country, designing their crisis response system. Nothing about us without us. And our young people sometimes feel invisible and they need to be at the table helping to influence how the crisis.

**Dan Gillison** (01:12:00):

And they need to be at the table helping to influence how the crisis response system will be built out. Otherwise, it will be built without them. So, that is also advocacy we need to do. And thank you very much for bringing that to the table tomorrow because we're 37 days from the national launch of 988 and that is simply the launch. The implementation in a few states will happen because they have built their systems, but there will be much more work to do and we have to keep our attention on it.

Let me get to the next question, which is one that came in, and Lisa opened up the session for us today and thank you so much for doing that, Lisa, by saying that when you've given presentations many times in person and wishing that this was in person, you ask everyone to raise their hand in the audience who's been impacted by suicide. And you said that the volume of hands go up and you also gave condolences. So, thank you for your leadership in doing that on behalf of all of us today. And that's the lead-in to this question. And if I might read it to you, it's important that I said that as I read it to you.

"It is difficult to find clinicians at present with long wait lists and hospitals are reluctant to admit given bad shortages. Having recently lost my son to suicide, I know the burden of keeping our children safe often falls on parents. How do you educate parents who are afraid and not prepared to screen and know what to do if their child is expressing suicidal ideation?" So, to that parent, our condolences first and foremost, and thank you for your strength in asking the question, and to all of you all, if you could give a response to that, we'd greatly appreciate it.

**Christine Yu Moutier** (01:13:52):

Well, I would look at it as any other health or safety issue that parents need to face when they become parents or when they become aware that there's a need to ideally proactively learn more. In order to equip you in your parent role as well as possible, we take that effort to get educated about everything from SIDS and crib safety to every other stranger danger and drugs and alcohol and online safety and security. So, I would say it's the same basic approach with suicide prevention that you want to learn as much as you can. And that is certainly one of the reasons that we created the blueprint was to try to wrap it up in one place as a go-to resource, not only for pediatricians, but for parents and community leaders as well to have not just top-level pie-in-the-sky language about this, but really practical information. And some of it is even templated scripts and things that you can do and say.

**Dan Gillison** (01:15:09):

Thank you. Any other thoughts on that question? Thank you, Christine.

**Lisa Horowitz** (01:15:16):

Yeah. I just want to say it is a really hard conversation to start, but it's not just one. Like everything else Dr. Moutier just said, talking about drugs and safe sex, and you have a lot of chances. You can even say it's awkward to talk about. There's a website called Seize the Awkward that has good examples about how to start. This video from the Mayo Clinic has some suggestions, but the main thing, and I think I wrote this in the chat, is the listening. It almost doesn't matter so much what your words are, so don't worry about finding the perfect words. The sitting beside your child, just being there, even on the phone, or just the fact that you're showing up, that's what matters the most.

**Dan Gillison** (01:16:09):

Yeah. And building on that, NAMI has programs that we provide in the communities like family to family, peer to peer. So, when we say you are not alone, this is for folks to sit there and understand, "Hey, there's someone else experiencing this" and these are evidence-based programs that actually help with the parents as well as the person with the lived experience in actually navigating and moving forward. So, there are some different types of opportunities in community, which is a part of this presentation today about community-based organizations. That's who we are, a grassroots organization.

We also talked about equity and many times we go past these questions. I want to come back to it, not because we have an answer, but sometimes you have to provoke the thought to make sure that we're at least putting it on the table. So, I do not expect that we have the answers here, but we did talk about equity so I wanted to ask the question. What are national indigenous leaders doing to mediate the abysmal stats for indigenous suicide nationally?

**Lisa Horowitz** (01:17:15):

Yeah. So, I'll tell you some of the things. First of all, hopefully, it doesn't just fall to indigenous leaders, right?

**Dan Gillison** (01:17:25):

Yes.

**Lisa Horowitz** (01:17:25):

It's everybody as a community. So, history and systemic racism, there's so many factors that go into why American Indians, Alaska natives have such high rates of not only suicide but drug and alcohol use and are really struggling communities. I can tell you one thing. The Indian health service, which has over 170 health facilities across the country, is now implementing suicide risk screening, and we actually are partnering with them. We started with a pilot in a few emergency departments that serve American Indians and Alaska natives. So, we're trying to get screening running up in the clinics, but I think it's a problem that has to be met upstream. Dr. Moutier mentioned the good behavior game and all kinds of things we can do and start with young children to really help a generation grow that doesn't have to be straddled with this issue.

**Dan Gillison** (01:18:40):

Yeah. Thank you very much. Christine, you brought up the pipeline to prison, and thank you so much for doing that. It was something that was very, very powerful from the standpoint of almost us addressing symptoms versus getting to the root cause. Can you speak a little bit more about that pipeline to prison and some of what you've seen and AFSP has seen in addressing that? And thank you, Lisa, for your comments on indigenous communities.

**Christine Yu Moutier** (01:19:10):

Yeah. What we're seeing is that when there is no effort to address the systemic racism that exists in all structures basically in our communities that haven't started becoming more knowledgeable and educated, that there is this again, like I said, misinterpretation of what might look like problematic behaviors that would normally, without these efforts, get a disciplinary approach. So, that youth quickly learns early on. Let's say there's ADHD or depression going on in a young black child's life, and now they are getting in trouble in school all the time. Their identity is forming, so they quickly start to realize "I'm a problem. I'm in trouble all the time. I'm a failure." And no one is picking up on the drivers of those behaviors. So, then when you train the school staff and, frankly, clinicians need training on this too. We all have our own assumptions based on the general population's attitudes that we've long carried for generations.

So, for example, when a school gets informed about trauma-informed basis for mental health experiences and behaviors, they quickly learn that many times behaviors that look like anger, outbursts, temper problems, agitation showing up late, academic struggles, that they're rooted in trauma or mental health distress. And when staff are able to get on top of that, instead of coming at them with a disciplinary approach, they can come alongside them in a more supportive approach to explore what is going on behind the scenes. There are some school systems that have shown remarkable results by taking on a trauma-informed approach. That's one type of approach.

But another one is a way to have mental health resources embedded in schools that are informed and then are actually able to identify those signs of mental health problems early and engage the youth and the parents in education and in treatment. There's a big issue with black youth and other minoritized communities as well with not only engaging them in treatment when it's appropriate but maintaining engagement in treatment. So, Dr. Michael Lindsey and others are studying approaches to change that trajectory so that we can actually afford the same level of effective mental healthcare to all populations. And to the people who are putting their experiences in the chat, thank you so much. And I know we are all well aware that access to care is still a major, major issue for all people, let alone for these marginalized and minoritized communities.

There are efforts going on that are very multi-pronged. Everything from workforce and being able to have a pipeline of people who represent and are culturally from the population so that they can be the healthcare providers providing care ultimately. That's the ultimate goal, and that's just one solution. It's longer-term, obviously, because it's a pipeline approach.

**Dan Gillison** (01:22:40):

Thank you very much. And that goes back to part of what Lisa presented when she spoke about the congressional black caucus report. Some of this information is in that report and to that work from the chair of Bonnie Watson Coleman, Michael Lindsey, and others that were engaged in that, thank you very much because we keep addressing symptoms. We got to get to the root cause. So, a lot of times these young people are feeling hopeless versus hopeful, and that adds to what we're seeing in terms of why this emergency task force on black youth suicide was created. So, thank you for that.

**Dan Gillison:**

I have one or two other questions. We're coming up to the end though. So, I want to stop and just give you guys the floor, Ask the Experts, and there may be something each of you are thinking, "I'd love to tell the audience this." So, I wanted to pause and give you that opportunity versus asking you a question. Is there anything that you'd like to tell this audience that you haven't been able to yet?

**Christine Yu Moutier** (01:23:41):

Well, we've talked a lot around the topic of people who are struggling and might be having suicidal thoughts that they keep it to themselves. While there's not time to get into all the reasons for that, if you haven't experienced it yourself before, know that when you are in that state of struggle, there is a very unconscious automatic thing that happens where you feel afraid. You feel that you might get in trouble if you speak up. You feel vulnerable and it's conscious and unconscious. So, in all of our efforts in suicide prevention, whether you're a parent who is worried about your child, whether you're a teacher, a policymaker, or a clinician, even a clinician with patients, even clinicians peer to peer with each other, know that human thing happens. So, we have to go above and beyond and lay the groundwork to establish ourselves as safe individuals.

And you can do that by saying outright, "I am worried about you and I'm coming from a place of caring and support. There is no problem too big." If this is my child, what I would say is, "There's no problem too big that this family can't handle together, and you are not in trouble for suffering. We all face challenges. It's normal to struggle at different times in our lives. We all do that. We all need to lean on support and together as a family, we can help this situation." And really, most importantly, open up a dialogue if possible where you start to listen to their experiences. And if they're not willing to share right away, it's okay. It's okay to come back later. And oftentimes what will happen is just by laying that sense of safety and support, later on, they might start talking.

Again, as a parent, you have to be ready for it because it might be at the least expected moment. You're cooking in the kitchen or you're driving in your car and suddenly they're talking to you about something that happened at school or at practice. You have to realize, "They're letting me into their internal world. These are their perceptions of what's happening and how others are making them feel." When they start to talk that way, drop all the business of the day and just be in active listening and supportive mode.

**Dan Gillison** (01:26:07):

Thank you very much. Thank you. Safety, support, judgment-free zone, listen intentionally. Okay. Thank you. And it's okay. It's a judgment-free zone. It's okay. Thank you very much. Lisa, Tamar, anything you wanted to add, and then we'll wrap up?

**Lisa Horowitz** (01:26:27):

I would just piggyback on what Dr. Moutier said so beautifully. One, make sure your child has a trusted adult to talk to. So, if it is not you, don't feel threatened. It's not because you're a bad parent. Most of the time it won't be you. If they have a neighbor, an aunt, a coach, a teacher, if they're talking to someone and, as a parent, you can feel a little jealous, be happy they're talking to somebody.

And use this. You don't have to wait for a problem to show itself. You can say, "Hey, I was in a webinar today where they were talking about something serious like suicide. Is that something that you see in your friend group?" make up the, "Hey I heard on NPR today" and just throw it in. That's what I do. Anything I want to discuss, I'm like, "Hey, today I heard a story on NPR." One day my daughter will find out, "Wait, mom, really? No."

**Dan Gillison** (01:27:23):

Yeah. Yeah. Thank you very much. Tamar, last word from you.

**Tamar Haro** (01:27:28):

Last word. I love being the last word. I'll just offer that, as an advocate and as someone who does advocacy professionally, it is a marathon, not a sprint. It is also a team sport and you are not alone. Advocacy.] I think sometimes can feel very, very difficult, cumbersome, frustrating, but just to really take time to know the power of your own voice, that many policymakers themselves don't know what you know, which is that you are a person with lived experience. You are a parent, you are an advocate, you are a clinician, and that gives you the power to talk about suicide and mental health from a very real, practical, and personal perspective. And there is incredible power in that, and that can be leveraged for policy change. So, whatever it is you're most passionate about on this issue and wherever it feels most comfortable for you to plug in whether it's social media or it's direct engagement with policymakers. NAMI, AAP, AFSP, we all have resources and ways to support your advocacy journey, but please know the power of your own voice.

**Dan Gillison** (01:28:37):

Tamar, thank you. Lisa, thank you. Dr. Moutier, thank you. As we show this and wrap up, this is about caring. People don't care how much you know until they know how much you care. And while we have experts with us with deep and wide knowledge and experience and research, it's about them caring. As Tamar said, we all have strength in our voices and there's power in our voices so we need to use those. We saw the question that came up and someone also mentioned the book. You are not alone. The NAMI guide to navigating mental health. There's over 130 different folks that were interviewed for this book and it talks about the guide to navigating mental health. So, there's advice, there's wisdom from individuals and their families.

And you can order this book through Zandoprojects.com/books/youarenotalone. And this is NAMI's first book, and we are very excited about it and we hope that you will be as excited as we are and order the book. There is our NAMI con. Our convention is coming up the 14th through the 16th of this month. We're strongest when we join together for mental health. We're trying to create this tapestry and construct this quilt. So, together for mental health, we'd love for you to join us, and you will see the registration site at the very bottom of the slide.

In closing, we want to again stress, you are not alone. It's almost like when you're talking to a young person or ... we're part of a cosmetic society. So, we see the jacket of a book and we say, "Oh, we're going to get that." We got to go to the table of contents and the chapters. So, when we ask people, "How are you doing?" Let's be very intentional and say, "How are you really doing?" We all give the cosmetic answer. "Oh, Dr. Moutier, I'm doing great." "Okay, Dan. How are you really doing?" So, let's just stop and pause and do that because we're at that point in 2022 with the last few years of COVID and what's going on in the world right now that we have to get past the cosmetics.

So, with that said, again, we want to close where we opened and remind you that the Ask the Expert is the informational webinar series, and you can read what it says right here, in terms of not intended to provide medical advice on any specific topic or offer any specific individual, and it's made possible through the generous support of people like yourself. So, if you're enjoying this, please consider donating at nami.org/donate. What we want to also close with is two last things.

**Dan Gillison:**

One, this is a very critical topic to us, and we're going to use Ask the Expert in the month of September. And normally we do one per month. We're going to do one for each week in September. So, we will have an Ask the Expert on suicide and suicide prevention and the conversation about it every Thursday in the month of September, so we really hope that you will join us. Last but not least is to acknowledge the staff because it's very important. When we open the curtains, when you go to a performance, you see the performance, you don't see all the work that goes on behind it. So we just want to acknowledge our staff for all of their work in terms of bringing this to you. Jordan Miller, Teri Brister, Jessie Walthall, and Zahira Correa. Thank you very much for your work, and we appreciate you.

Last but not least, NAMI's values. We have five of them and they are inclusion, empowerment, compassion, fairness, and hope. And that's what this is, hope. So, thank you all for everything that you do. We very much appreciate our Ask the Experts, and we appreciate all of you being at Ask the Expert on today. Wish you the very best in closing your week and hope that you all have safe and enjoyable weekends. Bye now.