NAMI Ask the Expert:
Suicide Prevention During Covid & Beyond – Science, Grassroots & Solutions
Featuring Dr. Christine Yu Moutier

Dan Gillison (00:00:00):

Teri, thank you very much. And good mid day, good afternoon to all of you all. This is a very important webinar today. And having lost a loved one to suicide, it would have been wonderful to have been on the other side of this, in terms of suicide prevention. Not having that opportunity, I'm very interested in this on today, and would just like to welcome you all on behalf of our board, our board president, Shirley Holloway, our staff, and all of our leaders in the state organizations and the affiliates and our volunteers. We really appreciate all of you all being here on today. And on behalf of everyone I just mentioned, welcome. And now I'd like to hand it off to our chief medical officer, **Dr. Ken Duckworth**. Ken?

Dr. Ken Duckworth (00:00:49):

Thank you, Dan. It's a real privilege today to have **Dr. Christine Yu Moutier**. She's the chief medical officer for the American Foundation for Suicide Prevention. It represents the best of academic rigorous science, practicality. And she also has lived experience, having lost colleagues who've died by suicide. Dr. Moutier was the Dean for students at the University of California, San Diego, where she really moved the culture for its acceptance of help seeking. She has been a national leader in impacting multiple populations, in veterans, refugee population, the Asian population. But I know her best for her work in changing the culture of medicine around seeking help, and the risk of suicide, which has increased for physicians, nurses and other healthcare practitioners. Please give your warmest NAMI welcome to Dr. Christine Yu Moutier. And I'll see you back at the Q&A section in about 50 minutes, plus or minus. Thank you, Dr. Moutier. We appreciate you, and we're thanking you for your efforts today and always.

Dr. Christine Yu Moutier (00:02:02):

Thank you so much, Dr. Gillison and Dr. Duckworth, it is such a pleasure to join you all at NAMI and your community. We know that we share so much of an overlapping national network of people who are personally touched by mental health conditions, lived experience of suicide and suicide loss. So I already feel like I'm part of your family, and vice versa. And in the next 45 minutes or so, I'm really going to be sharing just some of the highlights of things that have been going on, not only new scientific findings, but current trends in the culture and the opportunities that we all have to really elevate the dialogue around suicide prevention. And it does take both the growing science and answers to the really deep, important questions about what raises suicide risk, what elevates that, and what constitutes effective suicide prevention.

But it's not just the science, it's our own lived experience, whatever we have, and we all have lived experience to bring to the table. And it's that merging that is, I think, coming to bear at a moment when the world is now more ready than ever, as you all know at NAMI so well, to talk about mental health. To have the resources really increased so that we can live authentically, so we can live with a way that actually translates all of that science into real practice in our day-to-day lives, as well as, of course, into clinical practice for those who are clinicians, and for all of us who receive care by our

primary care or mental health professionals. So it's really like a very holistic look at suicide prevention. I'm first going to introduce our organization, AFSP, for those of you who aren't familiar with AFSP. I'm going to talk about the moment we're in related to COVID.

And of course that's not a monolithic experience by any means, but I'll talk about some of the highlights about the way we see the threats and the opportunities that the pandemic has presented, related to population suicide risk. I'm going to give a quick little primer on what our science helps us to understand suicide. And I'll go over some highlights of AFSP activities during COVID, and then resources to the public. And that's really also just meant to say that we want to do more with NAMI, and if there's an interest in any of the programs that I mentioned, there'll be a way to connect up on that. And I'll end my talk very ambitiously, just dipping a little bit into what's going on in terms of clinical practice that can reduce suicide risk. So it is a little bit ambitious, but I'm going to fly through it.

And more than anything, I look forward to dialoguing with you all through the Q&A at the end. So please don't be shy about putting your questions in. So at the American Foundation for Suicide Prevention, our mission is to save lives and bring hope to those affected by suicide. And like NAMI, we are a nationwide voluntary health organization, that really gives voice to those affected by suicide. And like I had mentioned before, is a true blend of science meets grassroots, so that we can take action, so we can inform our policy makers, so we can inform community leaders and clinical leaders about what it will take to reduce, not only suicide death, but also all of the suffering and the experience that surrounds that leading up to a suicidal crisis, and also including the experience of suicide loss. Which suicide bereavement has its own very special science and place of healing, for those of us involved.

We were founded 30 some years ago, by a group of families who had lost loved ones to suicide, and a group of researchers. So that merging of lived experience and loss and science, has been part of our DNA from the beginning. And we then have later, over the decades, expanded into what we consider a more comprehensive approach to suicide prevention. Where as the leading private funder of all suicide related research, and that's really globally, we are living amidst the science, but then trying to translate that as quickly as possible into solutions, again, at the community level and for clinical health systems. So that means advocacy. And again, like NAMI, we do a lot together in that advocacy space, which is wonderful, both at the national level as well as at the state and local levels.

We also have prevention education programs I'm going to show you. We have something called the Interactive Screening Program, that we could talk more about if there's interest in it. It's now being implemented in, not only colleges and universities, but in workplaces across all different industries. Which has been really exciting to see that interest grow on the part of law enforcement, entertainment, finance, tech, construction, believe it or not. All these various industries. We have very specialized programs and outreach for people who are personally touched by suicide loss, called our Lawson Healing Programs. And we have a chapter network across all 50 states, similar to NAMI of course, where all of these programs and advocacy actions can be taken up. So that nationwide community that we have, primarily of volunteers, again, like NAMI, those are our arms and legs into communities to be able to actually implement these programs, and change culture at the local level.

We talk about culture change, but it happens one family, one individual, one community at a time, while also there's this national change going on. So it is a really obviously challenging time. Here we are, almost what? 18 months into a global pandemic, which we thought might have a finite end, and is feeling more and more like it's not turning out to be that way, with the variants and the ongoing issues to be dealt with in terms of schools, workplaces, and the public health measures that we all are struggling with in different parts of the country. So what does that mean in terms of the impact when it comes to mental health of the population? And again, it's not to say that we are affected in the same

ways, we are all having different experiences. But I think one of the unifying things across all families and communities around the globe, and certainly around the US, is that the experience of loneliness, isolation, anxiety, uncertainty, some symptoms of depression, even PTSD, certainly for first responders and frontline workers and other exposed individuals during the pandemic, and suicidal ideation.

All of those are at a higher prevalence rate, than they are during pre pandemic times. So one of the key findings that was pretty early in the pandemic, was that one in four young adults, that's 18 to 24 year olds, endorsed having serious thoughts of suicide over the past 30 days. And that one in four data point, that is a much higher prevalence rate, than during pre pandemic times, it's between three and four times the usual baseline rate. So there's no question that distress is being experienced more prevalently, than pre pandemic times. However, what we know when it comes to suicide, is that suicide is very multifaceted. And I'll get to that in a moment. We also know, based on past natural disasters and war time, really any kind of population level disaster, that there are psychological phases over time that occur. And what I want to put this, is to layer this on top of what we know about how multifaceted suicide risk is, so that it's not an inevitable situation, that just because the pandemic is occurring that suicide rates will be elevated.

So I'll get there in a moment. I also want to show what's been happening with national rates of suicide over the past few decades, specifically since about 1999 or 2000, the rate had been going up year over year, a total of a 35% increase up until 2018. And then 2019, you can see there, we saw the first glimmer of hope in a way in over a couple of decades, where there was a downgoing turn, a small percentage change, about 2.3% decrease in the national rate of suicide. But again, because we hadn't seen that in a while, it was a glimmer of hope. There we go. This is by age, showing you the top 10 leading causes of death, suicide represented by the green boxes. Just so you can see, again, in 2019, where suicide was in terms of the top 10 causes of death. Now, when you look at this, you know that even though it's the second leading cause of death for 10 to 34 year old Americans, that doesn't mean that 10 to 34 year old Americans represent the largest group of people dying by suicide.

Because of course young people are dying much less frequently from any cause, because of their youth. But what it does mean is that these are potentially preventable, very tragic losses of life, across all of these different age groups. Part of what we're seeing in the culture, and when I say culture I'm talking about measures of attitudes, knowledge about mental health and suicide, and willingness to take the stigma out of the conversation and speak out authentically about our experiences. We know that culture has been changing significantly. We team up with some other organizations and conduct a Harris Poll about attitudes and knowledge about mental health and suicide, every several years. And during COVID, we did that. And it just keeps trending in a stronger direction, so that right now it's about 96% of American adults feel that their mental health is as, or more important than their physical health, as one example.

These are just a smattering of celebrities who have spoken out very openly, publicly, about either their mental health condition, their mental health, or their suicidal experience, or their suicide loss. And the reason I show this is just to give an example of how when you start looking for it, how the stigma is going down, and we are able to have these very hopeful, important, authentic dialogues. It is important that we use safe messaging, of course, especially when we talk about suicide. But that is actually happening more and more. And we at AFSP take this very, very seriously in terms of working with media, entertainment, content creators, journalists, and really anyone who has a position of influence. We want to make sure to help move the needle towards safer, more positive, effective dialogue from a public health standpoint, because we know that it's not just about keeping suicide

messages safe, mitigating contagion risk, but it's about the narrative, including a message of resources being available.

Mental health and suicide risk are dynamic, so we can actually influence them to some extent. And during COVID, I did publish a paper in JAMA Psychiatry, and another one in Lancet Psychiatry, with a group of international suicide experts, to look at what are the threats going on in terms of the pandemic and what we know about what the science says about suicide risk, and population suicide risk. So these are the buckets as we delineated them out, or that means there are also actionable strategies that we could take, mostly at a policy level, but also at an individual or a clinical level to reduce that risk that the pandemic might be elevating for the population. And again, for the longest number of months during COVID, we had no data, actually. It takes the CDC a while to package up suicide data. It's also true that in past pandemics, we've actually seen a little bit of downgoing suicide rate.

So it's not always a given that disasters lead to higher suicide rates. And this is just an example from the Spanish flu pandemic back in the early 20th century, where you see that overall mortality spike due to flu deaths, while suicide rates actually went down a bit over the couple of years around that time. So our work at AFSP has been, during the pandemic, to really emphasize a message of, now is the time, more than ever, to make the investment as a nation in suicide prevention to take care of our mental health. Because that can actually have a bearing on mitigating suicide risk, to stay socially connected as much as possible, to really emphasize that important message of community cohesion, that we are in this together. You saw in that disaster psychological response timeline, that community cohesion and sense of heroes and really encouraging them and encouraging one another.

That is something that we can be doing all the time, even though it's not an automatic natural thing at this later stage of this long running pandemic that we're in. We've been saying from the beginning, that suicide is not an inevitable outcome of the pandemic at the population level. And we've been using every opportunity that we can have through our chapter network, through our programs, but also through our media engagements. And over the past period of the pandemic, we have done a couple hundred national media engagements, trying to share these educational and hopeful messages around suicide prevention and actions, that any of us can take, which I'll get into in a moment. So our chapters converted over to virtual programming. I'm sure that NAMI has done something similar, to really stay engaged with meeting the needs of the community at the local level.

And our advocacy work, again, much of it with NAMI, has been, I would say more effective than ever, because I think during COVID there was this elevated awareness that mental health and suicide risk were seriously possibly in jeopardy, and that policymakers were coming around and really actually passing more bills and federal legislation, than probably we had seen in the previous several years put together. So it's a real time of readiness. And I'll just zip through some other visuals to help you see some of the ways that our wonderful communications team at AFSP, will put together the science and the content and the educational messaging into bite sized pieces that are more digestible, but really try to reach the public strongly through every avenue that we can. Okay. Here's just a snapshot of some of those public appearances. You can see that not only was it like Anderson Cooper in Today Show, but we'll engage with any group that has a reach into a community that we might not otherwise be able to reach.

So for example, the national PTA is an example of a group that we've worked with. There were some negative sensationalized media messaging, for sure, around COVID, specifically related to predicting suicide, which we should never do that. Because when we say that suicide is going to be a result of this, we almost create a narrative that makes suicide sound like an anticipated or even natural outcome or acceptable outcome. And that we never want to have that kind of dialogue. And I'll explain a

little bit more about why that is. We know from the science that suicide, while complex, is a health related issue. That means there's a lot of factors that come to bear. We also know from those of us with lived experience and the experience of loss, that some of the terminology around suicide from the past, really no longer make sense. And it's also very jarring to hear a phrase like commit suicide, when we use the phrase, commit a crime, or commit a sin.

And other health issues, we don't say commit cancer. So we have been trying to uproot that out of the lexicon in general. And we were successful at convincing the associated press to make that official change, and that recommendation is in the AP style book now. These are some of the organizations that we have partnered with, some of them quite routinely, and some of them came up as new opportunities during COVID. Now, what we found once the CDC did have preliminary, and that's all we have so far is, for 2020 we have preliminary mortality data, including suicide data. And what it shows so far is fairly hopeful that there was a 5.6% decline in the total number of suicide deaths in 2020, compared with 2019. What we don't know is the demographic breakdown yet, nor the geographical breakdown of that data. And there'll be some refinement from the preliminary numbers to the finalized numbers as well.

What we do know is that in a couple of states that have done the deeper dive, Maryland, Connecticut, as two examples, that residents in those states who were black residents, rates went up during 2020, whereas white residents, suicide rates went down. So we know that even if the total national rate is trending in a certain way, that doesn't tell the whole story for some important subgroup populations within the US, including by age and including by race ethnicity, rural and geographical, those are all considerations. And we know that over the years, not just during COVID, but since about 2010, 2012, there has been this insidious trend going on in black youth suicide rates, so much so that there are some very important initiatives going on, such as convened by the Congressional Black Caucus emergency task force on black youth suicide and mental health, that we support very much, and the legislation that's coming from that.

So just to wrap up this part about taking the temperature of this moment, we know that suicide as a population, as a whole, is not an inevitable outcome, even during COVID. There are some reassuring data, but also we're waiting for the more detailed data from 2020, and then of course later for 2021. We don't have any indication about suicide rates yet for the year that we're in right now. The silver linings that are really important that COVID has inadvertently provided to us, are around community cohesion, normalizing the dialogue about mental health experiences, and help seeking treatment and services. The bursting wide open of telehealth services has been very important, obviously, for accessing mental health services more readily, and the increased policy investment. But suicide prevention strategies really still need to be implemented at scale, which arguably has only started to happen at this point.

Okay, I'm going to zip through this next little section that is really trying to summarize a very complex science into just some top line ways to really understand the nature of what drives suicide risk, and what constitutes effective protection against suicide risk. Well, I would just start by saying something that I know is very, very well-versed to this group, I'm sure that I'm speaking with right now, that one in four Americans have a diagnosable mental health condition in their lifetime. About half of those with mental health conditions, the symptoms of those illnesses started expressing themselves by age 14, half of the mental health conditions come on early, 75% by age 24. And yet, despite all this great attitude change and the culture opening up, less than 50% of people with mental health conditions are accessing treatment and services. So this means we've got some gap between attitudes, and starting to incorporate that knowledge in a way that I call true deepening of mental health literacy.

And there's still the fact that when you are the one suffering, it's hard to open up about that experience of desperation, hopelessness, or suicidal thoughts. And we're trying to create a culture

where we are equipping people to be opening up that dialogue, and more able to identify when people are struggling. So one of the things that we know for certain from the science, is that suicide is not really ever considered a single cause and effect phenomenon. Another important thing that I've already alluded to, is that when you're the one suffering, you're keeping it zipped up. So how people appear on the outside is not usually telling the full story of what's going on, on the inside. And that means that we can do better as far as taking those subtle, sometimes, indicators of a person's behavior that's outside their usual patterns of behavior, and just checking in on them.

Because again, what we know from the science is that suicide risk is highly dynamic and multifactorial, so that you have genetic factors, biological, neuro-biological factors, psychological factors, issues of experiences of early trauma. That now we know from the field of epigenetics, for example, is not just something you experienced that is in your psyche, but it actually causes your DNA to express proteins in a different way, based on the experiences that we have. And those can be for good or for bad. So for example, while a traumatic experience may lead to ongoing struggles, and through that epigenetic phenomenon of gene expression changing, by getting treatment and support and processing and debriefing and working that through, you can actually conversely reverse that damage, if you will.

So it truly is a very dynamic situation. Now, when it comes to suicide risk, life events matter a lot. But see, it used to be thought that, because those were the only things you could see from the outside, that the breakup, the financial stress, the job loss, humiliation, and then the person takes their life. We didn't understand that all of those more invisible risk factors, were swimming under the surface and actually... In my mind's eye, what I envision with suicide risk is that vision of the gaseous cloud before the big bang moment in the big bang type theory, that all of those elements were there and interacting. But then in one moment, acutely, a reaction happens that's different. And an event happens that is suddenly very acute and explosively different.

And that's what the science around suicide risk tells us, is that many, many risk factors are there and interacting. Now, protective factors matter as well. So those are the things that we need to really, not only identify the risk factors, if they're modifiable, to mitigate them, but to accentuate protective factors like feeling a sense of connectedness, support, accessing mental health services, all of those things. And access to lethal means does matter a lot when it comes to suicide risk, so that's another mode of prevention, is keeping the home environment and the work environment as safe as possible, with lethal means secured to every extent possible. So just thinking about trying to put that into one picture of... So we know that what you see in a person who is struggling with suicidal thoughts, or specifically if they've died by suicide, in particular.

What you see on the outside, might've been that heartbreak, that loss, that job strain, but what you might not have been able to see are all these other underlying factors, as I mentioned. The genetic risk, the fact that they may have been dealing with depression, this is just an example. You could replace any one of these with any number of the known risk factors, prolonged stress at work, that they were drinking more than usual. All of those things are in the background. Okay. Let me get into a little bit... I think I've said enough about this model based on the science related to this multi-faceted, very dynamic interacting suicide risk. But again, what it tells us at the bottom line of all of it, is that while complex, suicide is ultimately a health outcome and a health issue. So that allows us to really take a public health frame on suicide prevention, because if we believe from the science that it is, well, complex, it's a health-related outcome.

That means a public health. We know from other examples, by investing in the science, in community and clinical programs, by taking stigma out of the conversation, that we're going to move

the needle on suicide prevention. And again, I would say that we are at a very early stage as a society, of actually implementing most of these levels of the public health to suicide prevention, to scale. But it doesn't mean I'm not hopeful, I am. I think there's a readiness and the public will is now there. Now it's a question of really making it doable, and leaders in all of these different sectors that I'm going to talk about, taking it on as a top priority. As we've seen happen, we've seen very hopeful stories with investments in research and programs and policy change around everything from HIV/AIDS, to various forms of cancer, to heart disease.

And we've seen very big impact from those actions in that public health model. So I'm going to do, now just a very quick overview, switching modes here a little bit, to show you how we at AFSP try to put some of this into action through our prevention programs and resources, that again, we would love to do collaboratively with you at NAMI. And also our chapters are putting these programs on even virtually. Most of them can absolutely be done virtually. Now the most recent program that AFSP has launched, it actually just launched in a more wide-scale way across our chapter network, is one that's really, really special. It's a program that teaches the loved ones of someone who has lived experience, meaning has either recently attempted or had a suicidal struggle, or has ongoing mental health and/or suicidal struggles.

So for the loved ones, where is the education around how to support them? And I know this has been a super strength and sweet spot for NAMI for many, many years. While we've taken it on in terms of that very specific piece of, if you have a loved one who has recently attempted or had ongoing suicidal struggles, what is your role to play? Because even if you have no stigma about this issue, turning that knowledge and that openness into skills that you take into a relationship and into your home, are two different levels. And that's why we created this program, is we felt that specific to suicide risk within a family or a relationship, that this information needed to be tailored. So we have two versions of this program, the deeper in-person program that's presented by an AFSP trained volunteer and a clinician, is called Finding Hope, guidance for supporting those at risk.

And that's a two hour program in-person. Since COVID is still an obstacle here in terms of in-person events in certain places, we do have a virtual, slightly lighter version of that program called Introduction to Supporting Those at Risk. So if that is of interest, you can contact us at AFSP. If you just put in your search engine, AFSP programs calendar, you'll see all of our chapter's virtual events in one calendar, and you could register for any one of those. They're all free to the public. Here's a sampling of some of our other educational resources and programs. Some of these we will partner with corporate partners, because they want to actually push it to their staff or to their constituents. But you can see that we have a very special program for LGBTQ suicide prevention, for those community members who are working with LGBT people or the families or themselves.

So it's a one day workshop that we put on, called Stronger Communities. We have programs for college students, like It's Real. That's a film that we made, it's real college students and mental health. Our More Than Sad, teen depression and teacher training. We have a parent education version of More Than Sad as well. We, as some of you may know, have a partnership with a gun trade group, that we were able to find common ground around suicide prevention by firearms. And it's an educational initiative, that by partnering with the National Shooting Sports Foundation, has provided us a trust factor, an entry into gun retailers and ranges. So there've been some very obviously innovative things going on. This is close to a full list of our youth suicide prevention resources. Although during COVID, boy, we got busy, we have a couple more programs launched, even during that period of time.

Many of you may be familiar with the model school district policy on suicide prevention, which is a collaborative resource that we developed with some other groups, that provide template language

for a school district, to either start creating their policy on suicide prevention for their district, or to advance their work in regard to that. We've recently had an independent, very academic research evaluation of one of our programs, More Than Sad. And it's the part of the program that teaches teachers and educators and school staff, even bus drivers and cafeteria staff, how to detect risk and how to coordinate their response as a school team. So this independent evaluation was recently published in the Journal of School Mental Health, just this year. And actually showed some very significant impact on, not just sense of knowledge and confidence, which is more of the usual way that we measure programmatic impact, but in their actual behavior of engaging with at risk students at a greater rate, and making those referrals to mental health professionals.

And those gains were kept even two months after the teachers were exposed to that. So we're excited about that evaluation. After a suicide has occurred, that's a very important moment that many of you know about, called postvention. Where there are a series of steps that will help the communication that comes out of either the school, the workplace, the health system, if it's a staff member or a trainee who takes their life. So that the messages are clear, sensitive, informed by the evidence. So that they do everything in their power to mitigate against the potential for suicide contagion. So it's both facilitating grief, that happens as a community. And this is hard on leaders, because look, they're fortunately not having to deal with this on a super frequent basis, so they're swimming outside their comfort zone when they're doing this. So that's why we made the toolkit for schools.

And actually we've customized that to a number of other toolkits. I'll show you in a moment. We have an ad campaign for 16 to 24 year olds, that's the target audience, called Seize the Awkward. If you haven't seen that, please check it out, It's very geared towards youth. So if you're in, probably even younger than I am, but generations above that age range, it might look different. It's about helping peers to feel more equipped to engage in more honest, deep dialogue, if they're worried about a peer. And we were very cognizant in developing this ad campaign with the Jed Foundation and the ad council, to get the balance right, because we don't want to place an overly sense of responsibility on any youth peers. But on the other hand, in many cases where a young person is suicidal, if they tell someone, in about two thirds of the case, they only tell a peer. So we did want to start deepening that mental health literacy as well.

These are some of the new programs that have popped up during COVID. There's this really sweet and great tool, a book called Gizmo's Pawesome Adventure Guide to Mental Health. And it doesn't talk about suicide, it talks about everything upstream. And this book and this school curriculum are geared for second through fifth grade students. So that's been a neat way to enter into the young child space in a way that's safe, because it's staying far, far away from any potential for the suicide topic or contagion, but it's really shoring up all of those social, emotional learning and connecting and trusted adult. But it allows children to take action on that, and actually to connect with a trusted adult. And we have a new teen program that's direct to teens, called It's Real: Teens and Mental Health, that tries to take that education deeper for youth as well.

We have a whole bunch of workplace initiatives as well. As Dr. Duckworth mentioned, myself and my two predecessors at AFSP, there have been three chief medical officers, and we've all really probably gotten our start in suicide prevention, because of an interest in being personally touched by either ourselves as health professionals struggling, or the loss of professional colleagues who are health providers. So now, of course, we're in the national space for all industries, all people, but we have a special niche set of resources for health professionals, and leaders, and people involved in medical education, and psychological education, to help equip them. So please check out that website if that's a

special interest of yours. As I mentioned, we've customized the postvention toolkit for after suicide, for a variety of different settings and more are coming.

We have one coming out for work places more generically soon. Believe it or not, these customizations are necessary, because they're such nuanced differences in each environment. So this is our current full suite of postvention toolkits, and you can find these all free for download on our website. Survivor day is a day in November every year, that is a time where around the globe AFSP helps interested parties, and you don't have to be an AFSP chapter, most are, but many aren't, host a day of convening suicide loss survivors. And it's a day of healing and connecting, where many loss survivors say they really got to start their healing journey, because we do that best when we're doing it in community. So it's a chance to connect and come out of a sense of bearing that, oftentimes, complicated grief on their own.

And just one example is in the case of our Los Angeles and Central California Coast event, Survivor day last November, the Senator made an appearance to talk about his own experiences. So every Survivor day has its own flavor, based on the leaders and the local interests that are there. There are hundreds of these events that go on every November. And last November, there were 26 international sites as well. So it's really neat to see groups in India and Kenya and the Dominican Republic, hosting a site that's for their community of suicide loss survivors. These are being done virtually, as well as in person. I mean, most of the survivor days being planned for this coming November are headed in a virtual direction, in a way unfortunately, just because there's such a power of convening in person.

Okay. And then just in the most recent cycles, again, as I mentioned, we've seen more federal legislation pass, maybe then in history. Now, again, NAMI is very much a partner with us in all of this work, and in most of this work. Our chapters have hosted 48 state advocacy days as well, so it's happening at the state level as well. And these are just some exam of some of the important topical areas that have passed at the federal level, and here are some of the important topics that have passed. We've seen legislation pass at the state level. And you'll notice that we do have a pretty strong stance on banning conversion therapy, and that has actually taken off across many, many states. That's been successful, because that has been shown to be so detrimental to LGBTQ people, and certainly youth who already have a higher risk of suicide, based on the environment and the discrimination that is faced.

I think what will see moving forward, probably in all of our advocacy work, is more of an emphasis on equity and inclusion, and understanding the needs of minoritized communities, any community that has been marginalized or really not been at the fore in terms of meeting the needs, in terms of suicide prevention. Okay. And my remaining few moments... Let me just... Okay. Let me cover a teeny bit going on in the clinical space, and this part will be brief, and then we'll move into the Q&A section. So what is happening in the health system and the clinical care arena of suicide prevention? And I would just say that we know a lot more now than we did 15 years ago. 15 years ago, if we had started universal screening for suicide risk, there could have been caring conversations and referrals into mental health services, but we didn't yet have safety planning. Lethal means counseling was not being trained on or widely adopted, and we didn't have as much evidence. And even in caring contacts, that research literature.

So it's a time, again, back to my first theme, that the science is shedding light and providing answers and new interventions, and now it's about implementation and scaling them. So that's what we're trying to do through project 2025, which is our nationwide initiative serving as a catalyst, obviously AFSP can't do this alone. To reduce the annual US suicide rate 20% by 2025, by partnering with the organizations and institutions that do have that kind of influence at scale. So what are we really

talking about, and what is the rationale for suicide prevention in clinical practice? Well, part of it is that in the past, suicide was really an orphan topic. It was not taught in medical school, psychology grad programs, even psychiatry residency training. Now, I trained a number of decades ago, but I did not have a robust training on suicide risk assessment or treatment strategies, again, because the science has grown that much in the last 25 or 30 years.

So health systems were built without suicide risk. I would even venture to say health systems were built without mental health in mind. I say that a little bit facetiously, but it is true. And then that's especially true that they were built without suicide as a potential clinical area of focus. So now it's really about going back and thinking, how do we make that an area for clinical focus. And it is picking up in the safety and quality medical arena, as well as through some other avenues. But part of it then is that, if somebody was found to be suicidal in primary care or in the emergency department, or in wherever, cardiology, dermatology, they were like, "Just punt it over to psych and to behavioral health, because this isn't our issue to deal with." Well, the issue though, is that people who later die by suicide, are being seen in all sorts of health settings within the days, weeks and months prior to their death by suicide.

So we're missing out on opportunities to detect their risk, potentially, and to provide that safety net of care and support that everyone deserves. And that right now we haven't built for that yet, but we can. So again, we're having these new answers and interventions that can reduce risk. Here are what we consider the brief, timely interventions, that I would say could be done and could be implemented in almost any health setting. And I know that sounds like a radical statement, but it's starting to be done in emergency departments and primary care, where it doesn't have to be... These roles can be implemented by the system, not all falling to one provider to take responsibility for them. And I want to make that really clear. So safety planning, lethal means counseling, an accessible, timely referral, having them walk out of the ER if they're not moving into a different level of care, walk out with all of these things, including crisis resources. And then have a systematic way that they are communicated with over the next several months.

I mentioned the caring contacts literature. What I'm talking about is this incredible and surprising finding in about 13 of 15 studies that have looked at it, that after a patient has attempted suicide and is being seen, let's say in an emergency department, or let's say they get hospitalized on a psychiatric unit. If that group, when they're discharged from the ED or the psych hospital, gets a series of postcards, text messages, emails, phone calls, or in-person visits, any one of those, but a series of them, it's usually between six and 12 over a period of 12 to 18 months, their subsequent risk of suicide attempt is reduced. The risk is reduced by between 40% and 70%, with nothing else changing in their care. So it shows you how, at the core, we are so socially wired. That caring communication, even if it's not terribly personal, actually means something at a conscious or even unconscious level.

And that should encourage us as well, that no matter what your role is, even if you are a family member or a colleague, a neighbor of someone you're worried about, that a dialogue and a message where you simply say, "I care about what you're going through. I want to understand more about what it is you're experiencing." Being non-judgmental, practice active listening and empathic listening skills. You don't have to be a mental health professional to engage in that level of caring communication, which actually is showing in the science to be potentially lifesaving, or at least contributing to that protective factor that can mitigate suicide risk. So these are the steps that we want all health systems eventually to take. We want health systems to provide education to all of their staff, clinical and nonclinical, on suicide prevention, as well as specifically on safety planning and lethal means counseling.

We want, routinely, patients to be asked, "Who do you want to be involved in communicating about your care?" Right from the beginning of treatment, so that we're not in the situation of now

you're in a crisis moment between the therapist or a doctor and patient, and now you're wanting to bring in family. But you've already had that discussion, and that you're involving the family appropriately. I mean, obviously the person has to consent to that. But right now, in my estimation, clinicians have been using HIPAA erroneously as a way to not even ask, and not try. We can put routine suicide screening and risk formulation, as part of the health system approach to suicide prevention, not just in behavioral healthcare, but even in primary care and the emergency department. And believe it or not, the accrediting body, the joint commission, is currently mandating that suicide risk screening be done in any health setting, where certain things are the case.

So if a person comes to the ED or primary care, and they have active depression going on, that's a person that according to their current national patient safety goal, must be screened for suicide risk. So we have the stick in place, but we haven't yet completely prepared a way or health system at a time, getting ready to change. Now may any are doing it, so don't get me wrong. The work is happening. I mentioned the system can put caring contacts in place. So that's not up to the doctor or the psychologist to have to make all those phone calls or send the postcards or text messages, that can be set up through the electronic health record, and ways that are going to be systematically done without putting the onus on any one provider. And the electronic health record can come alongside to assist with all of these steps, and document all of it as well.

So these are just a few. I'm going to be wrapping up here. These are a few just top line resources. Obviously afsp.org is our website. If you want to look at any of these programs and resources or connect with your local AFSP chapter. If you're a clinician and you want to know more about these clinical tools, well, I will be showing you. I did just release a clinical handbook, but you could also look on the joint commission's suicide prevention resource portal, and they have a number of links that are great. The safety plan is out there for public use, and then there's our youth public service ad campaign, Seize the Awkward. This is the clinical handbook that I released just a couple months ago. I wrote it for clinicians. Primary care, as well as behavioral health providers.

But there are also loss survivors and people with lived experience, who are reading it out of interest. And I think it's trying to do it all. I tried to make it so that for a busy clinician in the middle of their clinic day, it would be something that they could grab off the shelf and look up quickly, but it also has a lot of narrative that can be really helpful for anyone to just take their knowledge a little bit deeper about suicide prevention. So I've talked a lot and tried to just give you a glimpse into what we've been up to at AFSP, and the moment of COVID, some of our resources, and how much we appreciate the NAMI community and you all as an organization. So I will end there and hope that we can have some dialogue at this point.

Dr. Ken Duckworth (00:56:05):

Thank you, Dr. Moutier. That was a great talk. Let's get right to it in the first question. I recently lost a friend who died by suicide. How can I best support that family, knowing that I am mourning the person myself?

Dr. Christine Yu Moutier (00:56:22):

Yes, it's really tough, because for every suicide that happens, there is a family and a community of people who are affected. And we know so much more now about the suicide loss experience. I'm so sorry about this loss in your life. And what I would say is, take care of yourself, obviously, both for your own sake, but also so you can be present and supportive. I would say, certainly look on our website, because we have a whole bunch of tips and advice for how to support someone who's just experienced that and is being affected. But some of the top line tips are, don't be afraid to ask them open ended questions, and ask them how they're doing. Say their loved one's name. That's what happens a lot of times in the case of suicide death, is that people are so worried about saying the wrong thing or offending them, that nobody will talk to them about their loved one who's just died.

So obviously take the cue from them, how they want to dialogue, but the main point is, come alongside, just like you would if that loved one had died in a car accident or from any other health condition. Show up and be there. Think about the basic needs of that person too, just like we normally would, bringing food, offering to drive them to appointments, to watch their dog. Get practical things done.

Dr. Ken Duckworth (00:58:03):

Thank you. Next question. Two questions related to substance use disorder / addiction. And they both tie together, but I think the essential question is overdose death rates are way up. Do you think of some of them as suicide equivalents? Is it two independent streams? How big is the overlap?

Dr. Christine Yu Moutier (00:58:31):

It's been a really important question, that is unfortunately pretty vexing to really get to the nitty gritty dissection of the level of overlap. But certainly what we know, in terms of suicide surveillance, meaning how do we capture the data around suicide deaths, and everything that that involves at the county level, all the death investigator pieces, and then how it gets collected up by our public health system, ultimately, to the CDC? And what we know is that a number of suicides, that are likely suicides, are never called a suicide. And that in the past was probably a layer of stigma, less so now. But now it is the true problem that if there were not observable factors in the medical record, legal record, by families' observation, that it doesn't sync up. So it's not just an issue of suicide notes, suicide notes are left in about 35% to 38% of cases of suicide, but there is this...

So it's a long way of saying that there's any reason to believe that a number of overdose deaths, certainly that could have been the method of their death, by suicide, intentionally, without being able to capture that. Some experts like my colleague, Maria Okendo and Nora Volcao on the substance abuse side, we've all tossed it around that it could be anywhere between 25% and 35% of those overdose deaths, as high as that amount, that could have been suicides. Other people argue, "No, it's probably not that many." And certainly it's not [inaudible 01:00:28]. I mean, overdose can absolutely obviously be unintentional. But you bring up a very important point, the number of deaths by overdose was at an all time high during 2020. And so far the number of counted suicide deaths went down, as I mentioned, by 5.6%. So it's not as positive a story as as we would hope to be able to tell. And we need to be doing more collaboratively in the substance use area, to make a dent in suicide prevention.

Dr. Ken Duckworth (01:01:06):

Yeah. I'll do word association, two words. Social media. What do you have to say?

Dr. Christine Yu Moutier (01:01:14):

Oh, gosh. Yeah. I mean, there's no doubt that social media is shaping culture in some very broad scale ways, right? If you think about our generation of young people who have never known life without social media, and without the internet and screen time. So that broader view of, how has that shaped a generation's, not only attitudes and sense of self and other, but even potentially some of the neurobiological development of young children and teens, could be being impacted by that rapid fire novel stimulus. And some of those other phenomenon of fear of missing out and the comparison game, that are so common experiences to social media. But what I will say is, the science is not, it's very, very complicated. And I don't agree with the really simplistic messaging out there that some people will say that social media is the cause of the rising rates of youth suicide. I don't think we can say that. That, first of all, as I showed you, suicide is so multifaceted that it would be...

But it's an influence and it's a powerful influence. Now, some people learn how to harness their social media utilization for true connection, right? And it can be a way that we feel empowered, we see stigma reducing. So it depends on how you're using it. And for young people, I think it's just probably more challenging. The bottom line is, I have been teaching clinicians to start taking social media utilization as part of their clinical history, and specifically if you're worried... If mental health and suicide are part of your clinical targets with that patient, then you can be gleaning how they talk about their experience on social media, as it pertains to the impact on their mental health, and potentially impacting their risk for suicide.

So it is something to pay attention to. And for parents... My kids are 20 and 22 now, and I wish I could go back in time and do a couple simple things. I wish I could have set up, right from the beginning, charging cell phones overnight in the kitchen, outside of our bedrooms. I wish I would've had a basket that cell phones went into during mealtime, so that it was just part of the norm. And it's almost like it's hard to reign it back once they are into their teen years. But anyway, it's complicated.

Dr. Ken Duckworth (01:03:58):

I gave you a hard question. Here's one you're going to like. How do I become a trainer for the American Foundation for Suicide Prevention?

Dr. Christine Yu Moutier (01:04:06):

Oh, well, our trainers, our instructors or presenters, mostly are volunteers. So they are people who get involved with their local chapter, and just explore, "What can I do to get involved in suicide prevention?" And I will tell you that our chapters, many of them are quite sophisticated. They have volunteer roles where you can be involved in our Out of the Darkness walk. You can share that Out of the Darkness walk. You can be a programs lead, and that would mean, not just presenting our programs, but overseeing the chapters opportunities as it relates to programs. So we, in the national office at AFSP, put on webinars and trainings to help equip our volunteers and our field staff as well, to present these programs. So we would love it if you have that interest to let us know and get involved.

Dr. Ken Duckworth (01:05:12):

You mentioned the public health dimension of suicide, and one of the questions comes in. There's very different rates of suicide across the world, in terms of other countries. [inaudible 01:05:23] public health perspective, which I know you're a champion of, what do you think about the rates that are culturally driven in other countries, and how might we improve the situation here in the States?

Dr. Christine Yu Moutier (01:05:37):

Mm-hmm (affirmative). Yeah. Right. In the United States, our suicide rate sits in the middle on a global country's list, if you will. Among Western countries, we are in the middle to higher range. And where we've seen... Okay. So there are 39 countries that have national suicide prevention plans implemented, to varying degrees. For sure. Just like in the US. We've had a national plan since about 19... Well, the first surgeon general to make suicide prevention a priority, was in 1999, and that was surgeon general, David Satcher. The first time we had a modern national suicide prevention plan was in 2012, and that was recently just reemphasized and reiterated in 2020. The countries that have seen the most dramatic reductions in suicide rates, did some very significant things around lethal means reduction. In our country, obviously, where firearms are much more prevalent amongst the general community, 37% of households have firearms in them, in our nation.

And where it's so polarized. We have some issues, and that's why we have taken the tact to partner with, and try to go the education public health route with regard to firearms, suicide prevention. But for example, in Switzerland, in Israel, they've been able to... Oh, and in some of the Asian countries, this is really important, where pesticides are the leading method of suicide. They implemented some policy and training around pesticides and pesticide sales, that led to very significant reductions in suicide rates. So anyway, those are just a couple of thoughts on it. It's a really important question.

Dr. Ken Duckworth (01:07:51):

On the theme of means prevention, which is the acute method prevention, I was speaking with the leaders of the Jed Foundation yesterday. And they've had many college campuses across America really do a critical look at their means prevention. Do you have any thought or examples from that area? You just mentioned the pesticides. Of course English story about gas is also quite iconic. But what about that college means restrictions, and what have you taken from [inaudible 01:08:21]?

Dr. Christine Yu Moutier (01:08:22):

Yeah. Thank you. This is a really important part of the science of suicide prevention. One of the stronger, robust findings across the board, is that any effort that has either just naturalistically, like the UK coal gas story, that I can go into a little bit more in a moment. Some things just happen for other endemic reasons that are happening in a society. And then the ultimate outgrowth is that formerly popular mean of suicide, becomes less available or unavailable. And then you see the population rate of suicide drop by as much as 40%, that's a pretty consistent finding. So in the UK, it was just a story of, they used to use coal gas for their source of energy and fuel. And then as modernization was happening and it was changing over to other forms of energy, that means was no longer available in households in the UK. And the population rate of suicide dropped by 40%, even though other means...

So this really dispels the myth that securing lethal means won't make a difference, because there's this myth that some people have in their heads, that people who are bent on suicide will find another way. And in the majority of cases, they don't. And that relates to the timing of acute suicide risk, doesn't last for days and weeks, it lasts for minutes to hours. So if they live through those moments, there's a very high likelihood that they won't actually switch to a different method. There are other examples, there were some suicide hot spots in the UK as well, like there's a bridge in Bristol. That when they made that bridge safe, and there's a variety of ways to do that, as we all know, either through nets or barriers, that similarly by making that bridge no longer a means for suicide, they reduced that whole region rate of suicide by 40%, again.

So that seems to be, it's a very powerful... That's why when I show that bubble diagram with all those interacting risk factors, the lethal means piece is almost separated out, because you can singularly make a big difference in suicide risk by addressing lethal means.

Dr. Ken Duckworth (01:10:57):

Thank you. Question. How long should you stop talking about suicide risk with a family member who has an attempt? I appreciate this is a very individual question, but I think you've thought about this more than most people.

Dr. Christine Yu Moutier (01:11:18):

Thank you for that. And I'm assuming what they mean is, how many days or weeks should I wait before I stop checking in with them about suicidal thoughts? Ken, is that what you think they meant?

Dr. Ken Duckworth (01:11:32):

Yes. I think the idea is, would I be compounding a problem? At some point, should I let it go? And I appreciate this is incredibly individual. So you can't give too many blanket statements, but I think it's a real question that people struggle with.

Dr. Christine Yu Moutier (01:11:49):

Absolutely. And you're right. So each individual is going to have their own pathway to their being suicidal, and their own journey with how those issues get sorted out, and hopefully heal and address over time. And remember, suicide risk is very dynamic. So you can have somebody who is acutely suicidal in one moment, or let's say even attempt suicide. And in their recovery process, most will probably have suicidal thoughts come back at some point in time. Many will have ongoing suicidal thoughts. Just because they survived that attempt, doesn't mean that the drivers of their suicide risk have been resolved or addressed yet. But what I would do, if you have a strong open relationship with this family member, is I would empower them to help you know how this works for them, and how you can be as supportive as possible.

So it might be that they want you to check in with them every day, until they tell you otherwise. It might be that they say that, "When you keep asking me about suicidal thoughts, it's hard for me when you do that. And I'm not always having suicidal thoughts. So can you just ask me in a more open ended way, 'How are you doing today?'" I think it's a very individual thing, but I so appreciate the question, because what we're trying to do in our educational efforts, is help the individual be as empowered as possible to have a sense of defining and expressing what their needs are. And of course as a family member, and especially as a parent, spouse, anything, you worry so, so much.

And I have been there myself, I have family members with lived experience, two of them over the last about three years. So I have walked that walk before, and it is not easy. But I would say, try as much as possible to engage them, to empower them, to help you be a good supporter.

Dr. Ken Duckworth (01:14:28):

So it's really partly the courage to have the conversation, "How would you like me to support you?" Because you do have to be willing to take it up, to talk about. And I think for a lot of us, it's easier not to talk about it.

Dr. Christine Yu Moutier (01:14:42):

Yeah. And to make assumptions that I'll offend them, I'll upset them. But I think if you approach it in a humble way, and not just talking at them, but you're saying, "I want to support you. Can you help me understand what would be the most helpful for you?" I think that it's something we should be talking about. I mean, I think you need to have obviously some parameters, like if they say, "I never want to talk about this ever again." You'll say, "Well, this is something that we need to talk about, because it's affected you, and I care. But I'm willing to do it in a way that feels right to you." So really, again, trying to be respectful of their sense of their own needs.

Dr. Ken Duckworth (01:15:34):

Thank you. Excellent answer. Last question is really more, again, on the theme of teen suicide. The increase in the rates, the program you've put together. Can we just talk about teen suicide? Because it is a particular concern for many people right now. And that's the last question I'll be able to take. There's more than 300 people on the call, so sorry I didn't get to everything.

Dr. Christine Yu Moutier (01:15:58):

It's of huge concern, youth suicide. So pre pandemic, the rate of youth suicide had been going up since the year 2007, it started going up at that point. It had actually been on a down ongoing trend through the nineties and into the early two thousands. There are a couple things that happened in the world around that time, I mean, social media is one of them. The black box warning on medications for treating depression for youth, was another one that probably had some negative unintended consequences, of seeing that primary care were less likely to even diagnose depression, let alone treat it. But many, many factors that could have been influencing that rise. And again, in some of the subgroups that we think about, LGBTQ youth, black youth, Latinx youth, Asian American youth, certainly American Indian, Alaska native. All of those populations have different trends.

And it is still true that white populations, other than American Indians, white populations at all ages still have the highest rate of suicide. I take that back, with one exception, and that is in the young, young child age group, under age 11. It's awful to even realize that suicide started to actually happen at younger ages. Now, I do want to make it clear that of the almost 50,000 people who die by suicide each year in the US, the number of children who die by suicide each year under the age of 11, is in the double digits. So it's way too many, but it is still considered a rare event. But in that young child group, it is true that black child suicide rates have exceeded white child suicide rates. So that's what I'm talking about, in terms of this alarm bell going off about black youth suicide.

And it's not only the young child, there are trends also concerning... So during the pandemic it's a whole new world, in terms of how is it affecting our youth? And again, we don't know, because the 2020 data is preliminary and we haven't seen the demographic age breakdown, nor by race, ethnicity, except in those two states I mentioned, in Maryland and Connecticut, where black rates were higher than white rates. And we're trending in the wrong direction, versus white rates going down. I mean, it's a time more than ever, whereas parents, youth workers, teachers, youth pastor, anyone who has a connection to youth, I would just encourage you to be taking care of your own mental health, so that you can be present and observing what's happening in the youth around you. And connecting with the ones that you see some vulnerability emerging with.

And do everything that you can to support them, no matter what your relationship is. And also, when appropriate, to help link them to mental health treatment.

Dr. Ken Duckworth (01:19:34):

Dr. Moutier, what you're doing is brilliant, in taking on the hardest question. One of the hardest questions that we face as a human species. And in an America, you've noticed some important trends to attend to. So I'm going to hand this back to the CEO of NAMI, Dan Gillison.

Dan Gillison (01:19:55):

Thank you, Dr. Duckworth. Dr. Moutier, thank you so much for giving your time to us, and to this very important message. We appreciate it so much. And as we look at our, save the dates for the fall, we have events that we want to share with you, their Thursdays, the 21st of October, we will have members of Me Too Orchestra, and filmmakers of Orchestrating Change. On Thursday the 4th, we will have Dr. Gail Daumit from Johns Hopkins University School of medicine. And then on the 2nd of December, we will have Dr. Christine Crawford, who is the associate medical director of NAMI. And we look forward to all three of those. And the other thing that we want to say is, remember, you're not alone. And as Dr. Moutier talked about, it's not talking at someone, it's talking with them. And it's also saying, "I see you."

Now, let's talk about the Ask the Expert series. It's an informational webinar series, and it's not intended to provide medical advice on specific topics, or for any the individual. The series is made possible through generous, supportive people, like you. If you're enjoying this free programming, please consider donating at nami.org. And we appreciate your participation on today, and how much you care, because if you didn't care, you wouldn't invest the time to participate with us. And in closing, none of this work is possible without a team that's behind the curtain, that does all of the logistics to bring this together, the planning and the coordination, and that is Jordan Miller, Teri Brister, Jesse Waffle, and Leah Wentworth. And then our host always, Dr. Ken Duckworth. And on behalf of NAMI and all of our leadership, we want to thank the NAMI team for always bringing these Ask the Experts to us. We value and appreciate your work.

To everyone participating on today, we hope you have a great close to your Thursday, a wonderful Friday, and then just a fantastic weekend. Be safe, and know that NAMI's values are built into all of our work, and that is fairness, compassion, empowerment, inclusion, and the last one, which is a part of this today, hope. So we're looking for people to be hopeful and not hopeless, and that will take all of us. We value every one of you for participating today. We wish you the very best. Bye now.