NAMI Ask the Expert:
Suicide Prevention Series, Session 1:
The AFSP & The JED Foundation
Featuring Corbin J. Standley and Dr. Nance Roy
September 8, 2022, 4:00-5:30 p.m. ET

Teri Brister (00:00:08):

Good afternoon, everyone. Thank you for joining us early. We're happy to have you here this afternoon, and we'll be getting started shortly. Good afternoon, everyone. I'm showing four o'clock Eastern time, so we're going to go ahead and get started with housekeeping so we can get our presentation started. I'm Teri Brister, NAMI's Chief Program Officer, and I want to cover, like I said, some of the housekeeping before we actually get the presentation started. First of all, all callers are muted. Only the presenters have access to their microphone, so don't worry if you can't find your mute button. We've also disabled the chat for our ask the expert webinars, and this reduces distractions, especially since we've had an increased number of people attending. You can ask a question, and if you look at the slide in front of you, if you're not familiar with Zoom, you just click on the QA icon at the bottom and you'll see that on the slide, to type your question in. Hit enter.

We're going to be collecting those on the back end. We won't be responding to most questions actually in that pod. We'll be collecting them and then I'll be sharing them with the presenters at the end of the presentation. The call is being recorded. That's a question we get very, very frequently. And once the presentation is over, probably tomorrow, but more likely Monday we'll be sending an email out to everyone who registered to attend the presentation, that includes a link to the recording, a certificate of attendance, and a PDF of the slides that are being presented. So that's another common question we get, and you will get access to the slide.

Want to make you aware that you can also turn on your closed captions if that's helpful for you. We've had real good success with the quality of those captions, so feel free to use those. And another point on the link that you get to the recording, there will be a written transcript of the presentation there as well. People frequently like to have that. Next slide, Jordan. All right, and I will hand it over to NAMI's CEO, Dan Gillison to welcome you all to today's webinar.

Dan Gillison (00:05:05):

Thank you, Teri. And it's so good to be with you all on this afternoon for the kickoff of our suicide prevention series and part one. And I would tell you that as we look at this month, it's not just a month, it's every day. And the impact for a person that is a family member who has lived through losing a loved one to suicide and that ripple effect, as well as someone who has left us via a suicide, died by suicide, this is a lost individual that we want to do everything we can to make sure they know about resources, information, and they're empowered with knowledge to know that they are not alone.

Dan Gillison (00:05:57):

And so, we are so grateful that you are here. And on behalf of our board, our board President, Joyce Campbell, our staff and all of the field leaders and volunteers, we just appreciate everything that you do and that you are giving your time to this very important session on today. And I would also like to say that for this, to have both the American Foundation for Suicide Prevention and the JED Foundation here is incredible as the beginning of our series on suicide prevention. And the numbers are going in a direction that we want to change, and it will take all of us to do that. So, appreciate you being here, and from the NAMI family to every one of you, thank you for what you do. And now I'll hand it back off to Teri Brister to introduce our presenters and speakers on today. Teri.

Teri Brister (00:06:57):

Thank you so much Dan. And we want to remind you that if you need support during this presentation today or at any time, quite frankly, please remember that you're not alone. That's not just something we say at NAMI, we mean it. Feel free to contact the NAMI helpline via phone, email, chat, or text. And Jordan Miller, who is our executive producer, will be posting this in the Q&A pod as well, so you'll be able to see it during the presentation. As Dan mentioned, this is an up close and personal topic for all of us at NAMI. Lost my brother-in-law to suicide a couple of years ago and there's really not anything else quite like it. And we feel very strongly that it's part of our obligation and our mission to continue to not only raise awareness, but to provide options, tools, and resources for each of you joining us as individuals or for the organizations and communities that you work in.

As Dan mentioned, this is the first in a three-part series that we're hosting during the month of September, Suicide Awareness Month. And for this introductory segment, we're thrilled to engage two of our partner organizations, the JED Foundation, and the American Foundation for Suicide Prevention. I'm going to go ahead and share the bios for both of the presenters and then hand it off to them. To begin, first, we have Corbin Standley, who is a community psychologist and researcher who has more than a decade of experience in research evaluation and policy. His career is focused on public health and community level approaches to suicide prevention through capacity building, equitable systems change, and also policy change. In his work, he's prioritized equity and data collection, analysis, and reporting, as well as centering minoritized voices and co-designing equitable solutions. With those with lived experience as an expert voice in suicide prevention, his research in schools, health systems and communities has helped to transform systems to save lives.

As director of strategic program planning for Project 2025, which he's going to be talking to us about today at AFSP, he leads the translational science program development and implementation as well as strategic planning components of project 2020-25. He collaborates with interdisciplinary teams to create meaningful and lasting change.

Also, joining us today is Dr. Nance Roy, who is the chief clinical Officer of the JED Foundation and is an assistant clinical professor at the Yale School of Medicine, the Department of Psychiatry. She has over 20 years of experience as a psychologist working in college mental health. She served as the Assistant Dean of Health and Wellness at Sarah Lawrence College and most recently was the Associate Dean of Health and Wellness at Rhode Island School of Design. She has multiple publications and has been actively involved in strategic planning initiatives focused on a holistic approach to education, crisis management, and public health models for delivery of care in high schools and college campuses. We are pleased to have both of these professionals sharing information with us today. We'd like to begin with Mr. Standley for his presentation. Then he will hand off to Dr. Roy.

Teri Brister (00:10:35):

And again, as a reminder, put your questions in the Q&A pod for us and we'll come back to those at the end of both presentations, Mr. Standley.

Corbin Standley (00:10:44):

All right. Thank you, Teri. And thank you all for joining us today. I'm thrilled to be here and grateful to NAMI for hosting this series of conversations this month. As many of you may know, the American Foundation for Suicide Prevention is dedicated to saving lives and bringing hope to those affected by suicide. We have chapters in all 50 states, and we actually just chartered two new chapters this year in West Texas and Puerto Rico. AFSP creates a culture that's smart about mental health through education and community programs, further suicide prevention through research and advocacy, and provide support for those who are affected by suicide. As Teri mentioned, my name is Corbin Standley and I am the director of strategic program planning for Project 2025 at AFSP. And I'm here today to talk about our bold goal behind Project 2025. Next slide.

So today I'll be talking a bit about a brief snapshot of the issue of suicide in the United States and an introduction to project 2025 at AFSP, including it's four critical areas, the strategies and activities in each of those areas, and how we're counting on partners in all of these areas to help us achieve our goal and how we'll measure the impact of our efforts. Next slide.

We know that suicide remains a leading cause of death in the United States. This graph on the screen shows the rate of suicide between 1995 and 2020, and we see that we saw decreases in suicide rates in 2019 and 2020. We don't yet have data for 2021, but what we also know is starting in about 2005, we saw very stark increases in the rate of suicide. And so the time for bold, decisive action has arrived. And you can see that while we have seen these decreases in suicide rates overall, this has not necessarily been the case for all populations in the United States, and there's more that we need to be doing. Next slide.

Suicide is complex, but it can often be prevented, and this is insight that we gain through suicide prevention research. AFSP is actually the largest private funder of suicide prevention research in the United States. And research studies, the AFSP funds also help to set the tone and the agenda for national research and international research in suicide prevention. We know that there are actions we can take that are proven to lower the rate of suicide in communities, such as providing suicide prevention education, including frontline professionals and healthcare systems and educators. And by temporarily reducing access to lethal means with somebody maybe in a state of crisis. What's more, is recent Harris polls show that the majority of people in the United States believe that suicide can be prevented and that it's time to make suicide prevention a national priority, and that is what AFSP is doing with Project 2025. Next slide.

So, what is Project 2025? Project 2025 is a nationwide collaborative initiative developed and led by AFSP to reduce the annual suicide rate in the United States 20% by the year 2025. It's the bold goal at the center of AFSP'S Mission. Next slide.

And so to initiate Project 2025, AFSP convened an expert panel of the foremost experts in suicide prevention to help set the strategies for Project 2025. And together with their input, we commissioned a dynamic systems modeling exercise. Dynamic systems modeling is used to describe and project the interactions over time between multiple components of a phenomenon that are viewed as a system. So, what did our advisory panel and dynamic systems modeling determine? Next slide.

Corbin Standley (00:14:43):

There are a few things that we looked at. We examined, number one, who we are losing to suicide. We examined how we are losing them, where we are losing them, and finally, what actions we can take to save the most lives in the shortest amount of time. The results of these expert panelists and the dynamic systems modeling analysis determined our approach for Project 2025, and we can sum up this approach in a few steps.

Next slide. The first step was to review the data and scientific research to identify the settings and the best evidence inform strategies for preventing suicide within those settings. With the goal of saving the most lives the fastest. The next step was to start developing key partnerships within those settings and to invest in the development of tools and resources to support the delivery of suicide prevention programs within these settings. AFSP knows that we can't do this alone, and we need the help of leaders in all of the four areas that I'll describe in a moment to support our Project 2025 initiative in communities across the country. Once we identified those critical areas where we could make the most impact and identify the partners within those areas, we knew we would need to work with them to deliver the resources and programs in each of those areas at a national level, but also at a local level through our chapter network.0.

And finally, we were using what we learned, measuring our outcomes, and working to grow our partnerships and develop more tools and resources. With these four steps in place our goal, again, is to save the most lives in the shortest amount of time, and we've made great strides toward that goal. Next slide.

As you can imagine, this is an enormous undertaking. It was first developed in 2017, and we've got about three years left on that plan. And so that's a huge undertaking from assembling our expert advisory committee to determining the strategy and forming those key partnerships to help scale up those initiatives. There's a lot that's involved, and so to give you an idea of what's involved in the progress we've made, here's a look at some of the key milestones we've made in Project 2025. Next slide.

To initiate the project, AFSP convened that advisory panel to help understand the goals behind Project 2025. And so, our CEO, Bob Gebbia, and the board of directors decided to set that bold goal in 2014, and we formed that advisory committee in 2015. In 2016, we announced what the four focus areas would be, and five new project 2025 research grants were funded by AFSP. We've now funded over 30 million worth of research in suicide prevention. In 2017, we formalized a partnership with the National Action Alliance for Suicide Prevention on which NAMI and other organizations set to help get them on board for our bold goal. And they, along with other organizations, like Aetna and the CDC, have adopted our goal of reducing the annual suicide rate in the United States. Next slide.

2018 was another big year. We formally expanded a partnership with the National Shooting Sports Foundation, and through this partnership, we co-created suicide prevention education and materials for firearm owners. And the NSSF has made that available to their 8,000 member retailers and ranges across the country. Project 2025 was also endorsed by the Department of Defense and the Department of Veterans Affairs as a partner for preventing suicide for service members and veterans in 2018. We also funded additional research grants related to Project 2025.

Corbin Standley (00:18:23):

In 2019, we kicked off what we consider the next phase of partnerships and activity, including partnerships with the American College of Emergency Physicians, Aetna, and CBS, the National Commission on Correctional Healthcare and Safeside Prevention, just to name a few. This marked a key milestone because we now had partners in all four of the focus areas of Project 2025. In 2020, we celebrated an increase in federal funding for suicide prevention, and many states have begun to incorporate the goal of Project 2025 into their state suicide prevention plans. In 2021, one of our partners, CBS Aetna, set their own goal to reduce the renewal rate of suicide attempts among their employees 20% by the year 2025. Next slide.

So, the focus areas that we determined represent settings rather than subgroups of people because our expert panel determine that we can reach the most at risk individuals by focusing on these four settings. Next slide. Those four critical settings that we identified are firearms, healthcare systems, emergency departments, and correction systems. Now, of course, AFSP is focused on suicide prevention for all people in all settings. But Project 2025 is focused on these four areas because we determined based on our expert panel and our dynamic systems modeling, this is where we could save the most lives in the shortest amount of time. Next slide.

The first critical area is firearms. We know that nearly 20,000 people are lost each year to suicide by firearm. In fact, 51% of all suicides in the United States are by firearms, and over two-thirds of all firearm deaths are suicides. So, it was estimated that if half the people who purchase a firearm are exposed to suicide prevention education, and even if just a small fraction of those took action based on that education just safely storing their firearm, we could expect to save an estimated 9,500 lives through 2025.

Next slide. The next critical area is healthcare systems. We know that about 45% of people who die by suicide visit their primary care physician in the month preceding their death. And our modeling estimated that if even just one out of every five at risk people in large healthcare systems are identified through screening, including in primary care and behavioral health visits. And if they were provided with short term interventions that have that evidence behind them and are followed up with, that we can save 9,200 lives by 2025. Next slide.

In emergency departments, we know that 39% of people who die by suicide make an emergency department visit in the year before their death. And emergency departments present another key setting with a tremendous opportunity to save lives. And our modeling estimated that if again, just one out of five people seen in emergency departments are screened and provided short term interventions, it's a safety planning and follow up care, we could expect to save an additional 1100 lives. Next slide.

In terms of corrections, we know that suicide is the leading cause of death in jails in the United States, and it has increased 30% in recent years in prisons across the country. There are a variety of complex reasons for this, but what was estimated in our modeling was that if we screen for suicide and only identify even half of those who are at risk for suicide and identify what those key intervention points are, we could potentially save another 1100 lives within the correction setting. Next slide.

Corbin Standley (00:22:05):

So, in short, Project 2025, as an unprecedented commitment to positively impact our culture at surrounding mental health and suicide prevention by targeting systems for change in the suicide prevention space, the results of our analysis and our expert advisory committee based on what we know from the research revealed how we can save lives. But again, we know we can't do it alone. And so through developing standards of practice and guidelines and policies, through providing training and education across all of these settings, through implementing effective suicide prevention strategies and scaling those up across these settings, and through partnership and disseminating Project 2025 across our chapter network, we know that we can make a difference to save lives. Next slide.

Project 2025 is also a real time effort translating what we know about suicide prevention into practical real world solutions. And so we're guided by these principles in Project 2025. The first is to be nimble and innovative as new solutions arise. We're not afraid to shift direction if and when a better approach comes along. Our second guiding principle is to act as a catalyst for change by enlisting others within those four critical areas at both the national and the local levels. Unless we establish those key partnerships to put what we know into action, we know the AFSP reach alone is limited. Our next guiding principle is to leverage monetary and infrastructure investments made by others. We must build on the great work being done in suicide prevention and expand its reach, by working with our partnerships, by supporting our fundraising efforts, By funding additional research, we know that we can leverage those investments in strategic and thoughtful ways. And finally, we must monitor our impact and improve results and build upon the progress that we've made. We'll continue to evaluate or impact over time, so we can...

... That we've made. We'll continue to evaluate our impact over time, so we can double down on what is working and refine our approach in all of these areas. Next slide. Now that we've given you an overview of what Project 2025 is and what those critical areas are, I'm going to talk about some of the specific examples within each of those areas and the work that AFSP and our chapter network across the country is doing to make a difference in each of those areas. Hopefully this gives you an idea of how you can help us expand on Project 2025 in your own communities. Next slide.

We know through research that educating firearm owners on suicide prevention and how they can practice safe handling and secure storage, we can save lives. We've partnered with firearms retailers and large range of owners and other retailers to provide suicide prevention education in communities across the country. Through Project 2025, we show the firearms owning community how to spot the signs of suicide risk in themselves and others, implement secure storage practices, and promote help seeking behavior when they may be experiencing distress. We've collaborated with the National Shooting Sports Foundation, which is the leading trade organization for firearms ranges and retailers. And through this partnership, we're delivering an education and awareness campaign, which includes content on suicide prevention, safe firearm storage, and again, seeking mental health help for NSSF's more than 8,000 members, which is comprised of firearm retailers, ranges, and instructors across the country. The NSSF conducted a survey of its members in both 2017 and 2019, and found that 91% of their members said that they see suicide as preventable. And with exposure to suicide prevention education, that number grew by 5% between 2017 and 2019. And so we know that these things can make a difference within firearm learning communities. You can see some samples of the work that we've done with NSSF on the screen there with our brochure on firearms and suicide prevention, and our campaign of Have a Brave Conversation.

Corbin Standley (00:26:16):

These are all available for free on our website at Project2025.afsp.org, and they are also available on NSSF's website. As part of this collaboration, we've also developed a presentation called Talk Saves Lives, An Introduction to Suicide Prevention for Firearms Owners, which is a special module of our signature program Talk Saves Lives. And this is available for any of our chapters to present for free to anybody who is interested to learn more about how to safely store their firearm and how to recognize the warning signs for suicide. Next slide. The second focus area is in healthcare systems. And the key strategy in this area is to work with healthcare systems and accrediting organizations and governing bodies to accelerate the acceptance and adoption of suicide prevention strategies across healthcare settings, including primary care.

By working with these organizations, we know that we can accelerate suicide prevention in all of these settings. And these are just some of the partners that we work with in the healthcare space. For example, we partnered with SafeSide Prevention to implement an innovative and scalable suicide prevention intervention training to primary care physicians at practices across the country. And in the last year, we've actually increased the number of primary care physicians that have been trained by about 750%, reaching people across all regions of the country. This year, we're actually launching two new initiatives with the Institute for Healthcare Improvement and the American Academy of Pediatrics, both about working within systems to transform their policies and procedures around suicide prevention and to train healthcare providers on what they can do to prevent suicide, to look for warning signs and risk factors in their patients, and how they can effectively implement evidence based solutions in their clinics and practices.

Also, with the American Academy of Pediatrics earlier this year, we developed and launched the blueprint for youth suicide prevention in collaboration with the National Institute of Mental Health. And that blueprint is going to act as a guide for the curriculum for some co-learning collaboratives that we'll be launching in the next few months to train pediatricians on how to effectively implement suicide prevention practices in their clinics and with their patients. Next slide, the next focus area is emergency departments. And so remember I mentioned earlier that 39% of people who die by suicide make an ED visit in the year before their death. These settings represent another key opportunity to save lives. And so by working with emergency departments, we can help provide a safety net by educating and equipping emergency physicians and staff with the suicide prevention tools they need to screen and care for at-risk patients in emergency departments and in other acute care settings.

One of the big challenges to this is the absence of a quick, easy to follow procedure for emergency physicians. AFSP partnered with the American College of Emergency Physicians to develop and deliver a brief suicide assessment and prevention intervention tool called the ICAR2E tool. And this tool is freely available for use by any emergency physician, nurse, or medical student. And our partnership with ACEP empowers us to reach more than 40,000 members who are emergency physicians and professionals across the country. Next slide. We again know that suicide is the leading cause of death in jails, and it's increased by about 30% in prisons in recent years. And so by working with key partners in the corrections environment, we know that we can bridge the gaps in suicide screening, improve correctional healthcare training, and increase suicide prevention education in the correctional environment. AFSP partnered with the National Commission on Correctional Healthcare to develop and publish the suicide prevention resource guide to improve the standards for suicide prevention care in jails and prisons.

Corbin Standley (00:30:18):

We're also working on legislation at the state and the federal levels to look at things like solitary confinement and other suicide prevention strategies that we can build in from a policy level. We also recently launched just this year, our Talk Saves Lives corrections module, and we piloted this with the Indiana Department of Corrections, and actually have formed a partnership with them to train all of their correctional staff across the entire state in this program, which is training about 6,000 people a year through their annual training and through their new employee training. And so now all correctional staff throughout the entire state of Indiana are going to be trained in this Talk Saves Lives corrections module for how to effectively look for the signs and risk factors for suicide, how to safely intervene, and how to update their suicide prevention policies to be best practices.

Next slide. With the help of leaders in each of these four areas to support our Project 2025 in communities across the country, we know that we need partners in all of these areas. On the screen, you can see just some of the organizations that we're working with to help achieve the goals of Project 2025. I mentioned Aetna and the American Academy of Pediatrics and the CDC. We also work with the Education Development Center and The Suicide Prevention Resource Center, The Coalition on Psychiatric Emergencies. We've partnered with the NIH and the National Action Alliance on a lot of work and do a lot of work with ZeroSuicide specifically in healthcare systems. And we have a three way partnership with NSSF and the VA working on firearms suicide prevention with veterans in active duty military as well. To achieve our Project 2025 goal, we know that we need to partner with others to put suicide prevention efforts, programs, policies, and interventions into practice that will reach more people and help to save lives. Next slide.

To wrap up, let's take one more look at our ultimate goal and what we know we can accomplish if different stakeholders across systems and across those four critical areas, meet together to achieve this bold goal. With your help, if we can establish more of these key partnerships, scale up what's working, and again, be nimble and adaptive to new and changing circumstances, we know that we can reduce the annual suicide rate and potentially reduce it to its lowest in over 30 years. If we can implement these strategies in the ways that we've modeled, we could potentially save 20,000 lives by 2025. Next slide. And so thank you again for your time for listening to this presentation and to learn more about the American Foundation for Suicide Prevention and Project 2025, you can scan this QR code to take you to our website or visit Project2025.afsp.org. Next slide. And so thank you again for your time, and I will turn it over to Dr. Roy to talk about the JED Foundation.

Dr. Nance Roy (00:33:30):

Thanks, Corbin. And thanks for that really great presentation and excellent work that AFSP is doing. As usual, I would say, a very good friend to JED. I'm going to talk to you a little bit about the JED Foundation's approach to suicide and our target audience, the population that we focus in on are teens and young adults. My talk is going to be really geared toward how we prevent suicide and what our strategies are for those populations in suicide prevention. Next. For those of you who may not know who the JED Foundation is, we are... Are there dropdowns on that? I think they might be. Yeah. We are a nonprofit, a national non... Oops, could you go back? A national nonprofit, again, whose mission is to prevent suicide and significant substance abuse among teens and young adults. And we do this really from a prevention standpoint, so that we know, for example, if we really want to move the needle on suicide prevention, we need to move way upstream and really focus on developing positive mental health toward the end of course, of reducing suicides and substance misuse.

Dr. Nance Roy (00:34:53):

We do the majority of our work in schools. Since teens and young adults spend so much of their time in schools, we want to meet them where they are and support those institutions, where they really spend a tremendous amount of time. We partner with high schools and colleges across the country. We're currently in about a little over 400 colleges and universities working with them. And we just started our high school program about two years ago. And I believe we're up to about 70 high schools across the country as well. In addition to our work in schools, we also provide teens and young adults with skill sets and knowledge, most of which is online and on our website, to help them help themselves and each other. We have a number of stigma reduction campaigns and other mental health promotion campaigns. I think probably the one most folks know about is our Seize the Awkward campaign that we did with the ad council that is a series of short videos of young people reaching out to one another when they notice that their friend may be distressed.

You may have seen them on a bus or in a taxi cab or in a doctor's office. They're all over the place and we've gotten really great feedback from that campaign. In particular, what's important to note is in addition to the numbers of teens and young adults that have seen the campaign and watched some of the vignettes, the ad council has done some follow up statistics and studies to determine whether or not there was any actual behavioral activation as a result of watching the campaign. And in fact, they have found a statistically significant increase in the numbers of young people who have actually reached out to a friend to see how they were doing and to support their getting help if they needed it as a result of seeing a campaign. That's just one example of some direct to teen and young adult work that we do. And then we also work with community agencies, promoting community awareness, actions for young adults in the community on their mental health. Next.

As I mentioned, we are about teen and young adult mental health. Next. Our data obviously focuses on this population. We know that globally one in seven, 10 to 19 year olds have a diagnosable mental disorder, which is a pretty high number for that age group, 10 to 19 year olds. We know, for example, I'll skip over to the third box, given the first data point that age 15 to 24 is the age of onset for most mental health challenges. As you can see, one of our goals in working with young people is that it truly is in teens and young adults when we see the majority of the onset of mental health struggles, so obviously the sooner we can catch and treat when someone begins to struggle with a mental health challenge, the better the prognosis. Again, one in seven, 10 to 19 year olds having a disorder and the age of onset from most of those disorders is age 15 to 24. 30% of 18 to 25 year olds have a mental health challenge each year in the US.

The first data point was globally and the remaining are in the US. 28% of college students have reported suicidal ideation, hence our work in colleges, focusing on programs, policies, and systems that support college student mental health. Suicide is the third leading cause of death from people age 15 to 24, and the second leading cause of death for college age students. And 80% of people who died by suicide, as Corbin mentioned in his presentation, gave some sort of warning sign, a verbal or nonverbal warning sign. There are things to look for and there are ways that we can help. And the goal for us is to try and very early on at young ages. Next. Some subgroups of teens and young adults have been noted to be at higher risk for suicide. And those include youth of color, LGBTQ, international students, first gen students, and other potentially marginalized groups. They tend to face additional mental health stressors, and that increases their risk, not only for mental illness, but also for suicide. We also know that young adulthood developmentally brings many new experiences.

Dr. Nance Roy (00:40:11):

Puberty, for example, starting college, engaging in romantic or sexual relationships. There's many new sources of stress for young people, as they begin to navigate the world, as they begin to navigate the world independently, as well, exploring their identities, figuring out who they are, where they belong in the world, who are their friend groups, what's their place, where do they belong? Again, very important journeys for young people, but oftentimes marked with significant stress and anxiety. They've been experiencing trauma, abuse, discrimination, these particular groups, other forms of adversity, and all of these traumas and adverse situations increase the risk for mental health challenges and suicide. The good news, and there is some good news, that there seems to be a reduction in stigma among our young people. I'd like to say that's more generalized, but really we're only seeing a statistically significant reduction in stigmatization around mental health in our youth, but that is very promising and much more open in talking about their mental health challenges with each other and with others in terms of help seeking. That is a positive sign. Next.

What do we do? How do we work with teens and young adults? How do we reach them and what is our approach? Next. Here you will see our comprehensive approach for promoting mental health and reducing suicides and substance misuse. And this is our model, although slightly modified for high schools, this is our model for both college age and high school populations. And a few slides down, I'll talk about the modifications for high school. But as you can see, the model is a comprehensive model that focuses not just on access to care. We believe in a multi-pronged approach. And I will say that this approach is an evidence based approach that actually was developed by the Air Force over 20 years ago. And at that time, when they implemented this approach with these domains, they demonstrated a statistically significant reduction in suicides among the military folks, as well as, although they weren't looking for this, but anecdotally also found a reduction in domestic violence and substance misuse.

We took that model and modified it for use and application with our population of teens and young adults. As you can see, the first domain, if you will, is to develop life skills. We have found again and again in our work, especially with colleges and universities across the country, that many of the folks we work with in those institutions are telling us that they're experiencing students coming to campus far less equipped with basic life skills. That resilience for a large number of students seems to be at an all time low. And by life skills we mean things like managing conflict, dealing with disappointment, effective interpersonal relationship skills, other skills like time management, money management, sleep, things like that. But the relational skills, the conflict management, dealing with disappointments, navigating independence are essential skills for all, and especially when students who go away to college and who are now living independently really need to have developed.

And what we're finding and what the colleges that we work with are finding that without that good foundation of basic life skills, many students are thrown into situations where they're ill prepared to navigate the independent life that's required of them on campus. Really honing in with college campuses on developing life skills for those students who are coming to campus, ill-equipped in that area. I'll talk a little bit about how we do that in high school later on, but for colleges it's certainly very important. It's really a catch up if you will. The next domain we focus on is fostering a sense of connectedness and belonging. I'm sure many of you have heard the Surgeon General's conversation about loneliness and loneliness being an epidemic in our country. Absolutely true, especially for young people. And of course, as we know, the pandemic has exacerbated loneliness, isolation, and lessening feelings of connectedness.

Dr. Nance Roy (00:45:23):

One of the things we work with colleges and universities and high schools is how do we foster a sense of belonging? We want to develop both in high schools and on our college campuses, a culture of caring and compassion where there's no wrong door for a student to walk through for support, where everyone on a campus or in a high school has a role to play in promoting student wellbeing. As you can see in our comprehensive approach, while mental health and substance abuse services, so direct services, is one piece of the pie, it is only one small cog in a very large wheel. We are trying to get folks on campus, teachers, coaches, faculty members, academic advisors, security officers, res life folks, everyone across the board to be offering a warm hand, to be aware of students who may be struggling, not to turn everyone into clinicians. That's not what we're talking about, but we're talking about having a student feel comfortable, reaching out to just about anybody on their campus for support. This absolutely fosters a sense of belonging and connectedness.

Other ways in which we help schools promote this is among the students, so peer to peer interactions, peer to peer advocates, educators, counseling, peer to peer counselors, a number of ways, Big Brother, Big Sister programs, upper class students partnering with first year students to help them navigate their way. There's a variety of ways in which we try to help schools in this domain. And as I just started to talk about the next being, identify students at risk, I like to change that into identifying students who might just be beginning to struggle, because if we've waited until a student is in crisis or at risk, we've really waited too long. This goes back to that culture of caring, where everyone at a school or on a campus is trained to notice. For example, Nancy's usually talkative in class and lately she's been quiet for a few days. At that moment in time for my teacher or my faculty member to reach out and say, Hey, I've noticed you've been quiet lately. Is everything okay? What's going on? This is not rocket science. Again, not asking people to be therapists.

It's not rocket science. Again, not asking people to be therapists. Certainly know if I reveal an acute issue where to send me or get me connected for professional help. But we're talking about that outreach, that warm hand from someone who is organically in the young person's world who they know and trust. That offer of support and interest, quite frankly, goes a tremendously long way for helping students feel connected, feel a sense of belonging, and can begin to identify early signs of struggle.

And with the right support can hopefully not spiral into a much larger issue where in fact, they may need direct service. I mean, not every student at a school or on campus needs to be in direct clinical care. But they all can benefit from support. The next is increasing help seeking. Again, this goes back to students and young people really feeling much more comfortable talking about mental health issues and seeking help.

So we have some good news here. We encourage destigmatization campaigns. We have found one thing that's very effective is storytelling, for example. And I'm sure you've seen more and more, which is great, more and more stories coming out in the media, whether it's famous sports people or actors and actresses and other influencers, as they're called, speaking about their own mental health journey. Goes a tremendously long way, not only in terms of destigmatization, but also demonstrating for our young people and for all of us, but especially our young people, that folks can struggle with a mental health challenge and have a mental health journey and be successful, productive, and lead healthy lives.

Dr. Nance Roy (00:49:57):

And so the storytelling, both that we've seen more in the media, but also on campuses and in schools, if there's a particular school leader or someone who's very popular in your institution, whether it's a favorite faculty member or teacher or administrator, they feeling uncomfortable to tell their story and demonstrate that in fact there is hope and people do make it through their mental health journeys.

So, helping to increase help seeking behavior in our schools. One of the other really positive developments, as you know, is the amount of funding that has recently been released by both the state and federal government to schools in particular. A lot in K through 12 schools, but some as well to college campuses, on increasing access to care and having more opportunities for students to receive mental health services in their school.

Many colleges and universities have counseling centers, but not a lot of K through 12 schools necessarily have access to care in their institution. So that's a very positive sign. The next domain is actually looking at what services schools have in house. So mostly in colleges and universities, I would say. I think mostly in the K through 12 system, we see a lot of more guidance, more academic counseling. We see some social work opportunities for students to see social workers in the K through 12 system, which I'll talk about in a minute.

But with our college folks, we look at things like... And also in high school we look at things like how quickly can they get seen? Is there a triage system? Are there good connections to community providers in the area for when students may need a longer term experience, therapeutic experience? Do you have psychiatric services where students have access to medication?

There's a number of things that we look at. Is there screening at every visit for suicide? So we look at not only in our counseling center, but again, back to just validate and reinforce something that Corbin said is really focusing on in our high school and college settings on primary care. So the nurses in the K through 12 system, it's usually nurse based care and Fuller healthcare systems in our college setting, making sure that they are screening for mental health in primary care and holding students who have mild to moderate symptomatology in primary care for self-care treatment plans, motivational interviewing opportunities. Because we know especially on a college campus and typically high school as well, but certainly on college campuses, most of the students, upwards of 80% of the student body will go to their health center. Whether it's for a cold or a flu, that's their doctor now.

And whereas really a high number percentage wise for going to the counseling center is about 20% of the student body. So we know we catch a lot more students in primary care than we'll ever see in the counseling center. So if we're not screening in primary care and providing services there, then we really can miss a large number of students who may otherwise fall through the cracks.

So whether it's embedding behavioral health folks in the primary care setting or educating the primary care providers on how to do some basic motivational interviewing and self care plans, again, for those students who have mild to moderate symptomatology. Really goes a long way. We have learned again and again that you can refer a student to the counseling center all day long, and more often than not, they don't go. So unless you have someone who's in high acuity and you physically walk them over to a counseling center, the likelihood that you will lose them is quite high.

Dr. Nance Roy (00:54:15):

So, if we can hold them and screen and hold them in primary care, we'll catch many, many more students. We also look at crisis management procedures. So how are we supporting young people when they need to take time away, when their mental health challenges have gotten to a place where they really can't function independently or keep up with academic work and they really need to take some time away to care for their mental health? Because you've probably read quite a few stories in the newspaper. It always makes the news when students sometimes say, "Oh, I was forced off my campus." I can tell you that that very, very rarely happens. But we work with institutions to really look at what are their crisis management procedures? What are their medical leave policies? What are their return from leave policies? What are their substance use policies?

Are they focused on prevention and education and support and treatment? We are hoping to create a culture where students feel well supported and encouraged and applaud it actually when they're wise enough to know that they need to take some time away to care for their mental health and welcome them back with all the support that they may need when they're ready to return. So we also in this piece look at postvention. So when there is a death, a student death, how is the school or college responding to that? What is the messaging like? How are we supporting students and faculty and staff who may have been affected? How are we dealing with families? There's a tremendous, actually, resource out there that was put together by the Higher Education Mental Health Association of which Jed is a part that really goes through soup to nuts on practices and recommendations for postvention.

And then lastly, mean safety. And Corman spoke quite a lot about this and I'm so glad to hear that the 2025 initiative for AFSP is has mean safety as one of its elements. We know that reducing access to lethal means is the single evidence based practice to reduce suicides. If you don't have access to lethal means you won't die by suicide. So really looking at school systems, especially colleges, how are they promoting mean safety. Not just with firearms. And there are certainly a number of campuses that allow firearms on campus. So are there things like safe storage, locking firearms, separating ammunition from the firearm itself? A number of practices in that regard. But also things like controlling toxic substances. Are they secured? Are they in locked facilities, locked places on campus? Are there medication... Oh, what do I want to say, boxes on campus for medication disposal, secure medication disposal for unused medications. Prescription depositories, for faculty, staff, and students actually, and teachers.

For college campuses that have residence halls. Do the closet rods, are they breakaway or do they not support the weight should someone attempt a hanging? So there's a number of things that we look at around mean safety, including firearms, but not exclusively firearms. So as you can see, there's a lot to the model, and we do believe that in order to really prevent suicide, we need to take this comprehensive approach. And I should say, I should have said at the beginning, but I'll say now, really, our model is founded on two guiding principles.

And that is we must take a public health approach if we want to move the needle on suicide prevention and reduction. And in order to do that, again, we talk about a campus-wide or a school-wide approach where everyone has a role to play. So that's guiding principal number one. And number two, you need to have support from the top down, from senior level administrators. We found again and again, if a school or a college doesn't have those two things in place, it is very hard to move the needle in this work in any kind of long term systemic way.

Dr. Nance Roy (00:59:04):

So that's the model. How do we implement this model on campuses? And I'll talk a little bit about the journey. So the JED Campus program, so that's for our colleges and universities, is a four year collaboration with JED. We look at policies, programs, and systems. So we are a systems change program with the colleges. So indirectly impacting youth by looking at systemic policies, programs, and systems on campus. We provide assessment tools, technical assistance, ongoing TA and and post-assessment. Actually an online learning center, a resource library, a learning community, and a full range of institutions that we work with. Next.

So this is sort of the nitty gritty of the JED Campus program. We start by being consistent with our model and our guiding principles. We start by having the school develop an interdisciplinary team to work with us. So, again, campus wide, everyone has a role to play.

So we want to see faculty, staff, students, security, athletics, academic advisors, res life folks in a college setting, Greek life, if you have it, legal, you name it, across the board, you get the gist to work with JED in this four year program. We begin, once the team is formed by having them take the JED campus assessment. And that is an assessment that has questions on each one of those domains that I just spoke about. So do you have this, this and this in life skills? Do you have this, this and this in help seeking, et cetera, et cetera for all of the domains? Most schools tell us that once they've completed the assessment, they have a pretty good idea of where they're doing well and where they have gaps. At the same time as the team takes the JED assessment, the school also administers the Healthy Mind study to their students.

So the Healthy Mind Study is one of two well known national data collection for schools, high schools and colleges. The other for colleges is National College Health assessment. We chose the Healthy Mind study because it focuses primarily on student mental health attitudes, awareness and behaviors on student mental health. So while we are looking at systems change, we also... And what's good and bad and the systems, policies, programs and systems on campus. We also want to know what's the pulse of students on their level of awareness, awareness behaviors and attitudes toward mental health. So the school administers Helping Minds, they take our assessment and then we actually take all of the data and create a feedback report that shows again, where schools are doing well, where they have gaps. And we use that data to help the school develop a strategic plan with concrete goals and action steps to fill the gaps that have been identified by those two data sets.

That takes most of the first year. We also come to campus to do that work. So we come to campus to work with the team for one or two days to develop that strategic plan based on the data and the feedback report. And then the work of implementation really begins. So every school is assigned a campus advisor or a high school advisor to guide them through the work of implementation. So what resources do they need to meet their goals? Do they need to be connected with other schools or that are working on a similar initiative that have had some success? So offering ongoing guidance and consultation to help them meet the goals that we've outlined together to meet their gaps. At the same time, they're part of the learning community, which I mentioned come together multiple times a semester in webinars to talk about themes that are emerging that we're hearing from our campuses, to talk about how things are playing out on their campus, strategies they've used that have been successful, as well as an online resource library so you can go in and find any number of resources.

Dr. Nance Roy (01:03:42):

And then toward the beginning of the fourth year, we reassess. So at this point, they take the JED assessment again in administrative healthy minds again, and I will say that the Healthy Minds data is really the interesting data at this point because they've been tracking their progress toward goals with their campus advisor or their high school advisor on their systems work.

So there's really not a lot of surprises when they retake that assessment. What's interesting on the Healthy Mind study is we have matched our theory of change. So what are the things we think ought to have changed as a result of your systems level work with JED? What is the impact on student outcomes? So we've matched our theory of change with specific modules and specific items on the Healthy Mind study that we're tracking over time because we want to see movement in student outcomes.

I'll give one example. So, if let's say at time one students are saying they really don't know how to identify a sign of struggle in a friend or they wouldn't know what to say or where to send them for help. We would be working with the school on increasing awareness in those areas so that at time too, we should see a very different response from our students. So in a nutshell, that's the program. And then schools stay on as alum, hopefully if they choose to do so and stay part of the learning community.

Next, just some of our campuses, as you can see, we're pretty well dispersed across the country. Next, the high school comprehensive approach is very much the same. I won't go through it again. The main shift obviously is it's development. It's tweaked to be developmentally appropriate for the younger age group. But the domains remain the same and the work is the same. Next, that high school program is a three year initiative.

That's sort of the main difference between the campus and the high school program. And it's a three year program because we find in the high school systems, it is more difficult to sustain a four year program. And it's sort of more natural in the college setting since students are there for four years. So the three year program, again, very similar trajectory, the assessments, the strategic planning, the technical assistance, the post evaluation, and then the sustainability phase. Very much the same as what I just described. Next.

Some of our high schools. Next and resources. Next slide. So these are national resources that hopefully you'll have access to the slides that we highly recommend, the Trevor Project. We actually just did a project with the Trevor Project and produced a guide for how best to support LGBTQ plus youth.

You can see all of these for yourself. And again, please access these resources as you need them. Next, our own resources, please feel free to go to the JED Foundation website. We have many, many, many free resources on our site that we encourage you to a access and take for what you will. I will say I did just want to point out on the right hand side of the screen, the Set to Go program.

We talked about the high school and campus program. I talked about the Seize the Awkward Program, the Mental Health is Health program is a digital campaign, but our Set to Go program is geared to high schoolers, to teachers, administrators, and students. And it's back to what I was talking about earlier, helping to foster resilience and help students build life skills before they get to college. I encourage you if you have any high schoolers to go to this program there's tutorials for the high school students themselves, but there's a huge amount of information on how to help your student or your child begin to develop these life skills in high school so that they're ready for the transition out of high school. Whether it's to college or to the world of work.

Dr. Nance Roy (01:08:27):

Next. Other ways that you can engage with JED is through our campaigns on Instagram, Facebook, and Twitter. These are just some of the campaigns we currently have, specifically for suicide prevention awareness month. And next, our high school and campus programs. If you want more information on either of those and next, that is it. So thank you very much and I turn it back over to Teri.

Teri Brister (01:09:03):

Thank you so much to Corbin and to Dr. Roy for those presentations. Such a tough topic. That's an understatement, but you very much through both your presentations shared the variety of strategies that are out there to make an effort to begin to address it. And I'm mindful of it taking a village because that very much is the case with this. We have a lot of questions for both of you.

I'm going to do my best to get to as many as we possibly can. But before we even dive into questions, I just want to acknowledge the participants that are on the call today. And we typically have about a third of the participants are people who have personal experience with the topic about, a third are family members or caregivers, and about a third are from the professional space, either healthcare, law enforcement, etcetera.

But I'm especially mindful of people on the call today who've lost a loved one to suicide and who are on the call because they're committed to trying to pay it forward to help those who experience this in the future. So, with that said, the first one is for this question, Corbin, is for you, what are the state AFSP chapters doing relative to the project 2025 initiative? And specifically, how are they connecting with partner organizations such as NAMI chapters and affiliates?

Corbin Standley (01:10:46):

Yeah, that's a great question. One of the things that we are very proud of at AFSP is our chapter network with chapters in all 50 states. And so each chapter has a staff person as well as a volunteer board of directors who oversees their business plan and outlines their plans for the fiscal year and what they're going to prioritize.

And Project 2025 is a part of that business plan. And so really every chapter approaches project 2025 a little bit differently. And that's by design because we know that a one size fits all approach to suicide prevention isn't necessarily the solution. What works in rural Montana might not work in urban New York City. So each chapter sort of determines what they want to select from our sort of menu of programs and initiatives the AFSP and project 2025 has. And so within the programs and the initiatives that we offer, each chapter can kind of select and determine what they want to do. And a lot of the initiatives and partners that we have developed have come from the chapters and come from the grassroots level. For example, the partnership with the Indiana Department of Corrections, that came from a volunteer who knew somebody who was a corrections officer.

Corbin Standley (01:12:02):

Volunteer who knew somebody who was a corrections officer at a facility in Indiana and was interested in Suicide Prevention Education Training so we developed a module. We piloted there. We're now training 6,000 people across the state and launching that program nationally. So a lot of it also comes directly from the chapters because they are the experts of their local context and what their community's needs are. And then there's also the implementation of a lot of our programs. For example, our Talk Saves Lives Firearms module, SafeSide Prevention, SafeSide for primary care. All of those presentations are things that are packaged and ready to go that chapters can take and run with. They can build that into their budget and provide those trainings free of charge, especially our Talk Saves Lives modules. Those are free of charge to anybody who is interested in those.

And then they also do a lot of outreach with organizations across all four of those critical areas as well as with all of the other initiatives the AFSP does. So they're reaching out to healthcare systems, they're reaching out to firearm retailers and gun ranges, even dropping off a box of brochures at a local gun range so that those who are going to that range throughout the day, they have those brochures on the desk around firearm safety and suicide prevention. There's a lot of different ways that happens and our national team at Project 2025 is always there to support those efforts.

Teri Brister (01:13:32):

Terrific. And I'm assuming that people on the call who are interested in contacting the AFSP organization in their state can reach out directly as well?

Corbin Standley (01:13:42):

Absolutely. And they can go to afsp.org/chapters and you can be directed to whatever the local chapter is in your area and they would love to hear from you.

Teri Brister (01:13:52):

Terrific. So, Nance, a simple question and then I have two very complex questions for both of you. So Nance, multiple people wanted to know what JED stands for. Does it stand for something? Where does the name of the organization come from?

Dr. Nance Roy (01:14:10):

Yes, I should have said that when I talked about who we are. I usually do. So it doesn't stand for anything. So JED was founded by Donna and Phil Satow, whose son, Jed, died by suicide when he was in college. And so hence, they obviously walked away from that experience really feeling like this was over 20 years ago. Not a whole lot was being done in this space, especially for that age group. We've made progress, but we still have a long way to go. So they started the foundation in his name.

Teri Brister (01:14:46):

Which again speaks to the resilience of families and that we can all make a difference and if we just plug in. So these are two different but connected questions and they're very complex and I'd be curious to hear responses from each of you. Is there data specifically on suicide by cop and how that impacts suicide rates? And then the other one is similar in school shootings and suicide rates or suicidality connected to individuals involved in mass shootings, specifically at schools. So very complex, just no right or wrong answer, but just would be interested in both of your thoughts or your organization's perspectives.

Corbin Standley (01:15:43):

Yeah. In terms of the first question, suicide by cop, it is definitely complex in terms of the nature of that sort of death and also in the way that we collect data nationally and at the state level. Often, that's going to be classified in death records as a homicide because depending on how you define it, the person certainly interacted with law enforcement with an intent to end their own life as a result of that behavior. But depending on how a state or a coroner's office or a medical examiner is defining the terminology around what that intent is, it could be classified as a homicide as opposed to a suicide. So we don't really have firm numbers on suicide by cop. It is certainly something that is a priority. Something that we've certainly championed in this crisis intervention training for law enforcement.

So, they are trained in how to effectively respond to a mental health crisis or somebody who may be in a situation like that and can effectively deescalate those situations. This also relates to the work around 988 and crisis response services and building a continuum of crisis response services so that when there is an emergent mental health crisis call, it's not just law enforcement that are responding to those calls, but that we can dispatch social workers and mental health professionals to respond to those calls as well. So, it's certainly complex, but unfortunately there isn't solid data around that issue.

Dr. Nance Roy (01:17:27):

Yeah, I agree with everything Corbin said. And I will say there also has been a movement that we encourage all of our schools, high schools and colleges, to educate our, oftentimes they're called security, not always full police folks, but in some cases there are police and/or security folks to be educated. It's interesting when we start to work with a school, oftentimes security folks will say, "Well, why am I on this task force?" Or "Why am I on this committee?" And once we explain, they're like, "Oh", and they are an integral part. So educating them on how to respond to students when they're in crisis and having mental health challenges as well as many schools are moving toward the model that Corbin just discussed, which is having a mental health professional, usually a social worker, a company, a security officer, or police officer when they respond to a call.

As far as the school shooting one goes, again, I am not aware, maybe Corbin is of any really reliable data set. And similarly with the first question... I actually was just giving a talk on... I gave an interview actually because I was asked to talk about do schools track suicides? And again, the reporting, many schools don't. Some schools do, but the reporting is always, I can't think of a better word, but to say contaminated. It's just inaccurate because oftentimes, as Corbin was saying, in the situation with police, it may be classified as a homicide on campus, it may be classified as an accident, an overdose death or car accident or any number of things that may be ruled an accident when in fact it could well have been a suicide. So the data is very complex and I think it just inaccurate. It would do the best we can, but I think inevitably it's inaccurate.

Teri Brister (01:19:41):

And contaminated sounds like a bad word to use, but it really is probably accurate because we really don't know. It depends on how things are categorized. So you both hit on... I have a million different questions above and beyond the ones I have written down, but you both just touched on two important topics and one of them came up in some of the questions. One of you mentioned, or both of you mentioned, 988 and then also CIT training, the crisis intervention training. So one of the questions that came up was your thoughts about how 988 or the implementation of 988, how do you see that impacting the work that both of you do? So I'm curious about your thoughts on that. And I'm also going to add in the chat or make an effort to add in the chat. So Jordan, if this doesn't work, if you can do it, I encourage folks to go to NAMI's website to look at 988 Reimagine Crisis Intervention for some information about 988. That's a whole nother series of webinars. But curious from both of your perspectives at your organizations about how hopeful you are.

Corbin Standley (01:20:59):

Yeah, we know 988 has definitely been a priority of AFSP and we've been, along with NAMI and others, advocating for a three digit suicide and mental health crisis line for years. And now as of July, it's been rolled out nationally. And so we're certainly grateful for that. One of the things AFSP has also been very focused on, again, along with NAMI, as you know, we're partners in that reimagining crisis initiative and have been on those calls as well is can... The 988, the lifeline is an important component of a crisis response system, but it's one component of a larger system that we're hoping to build capacity for at the state level and at the federal level. We really want a whole continuum of crisis response services so that people have someone to call, someone to respond and somewhere to go, which is something again, NAMI has certainly been a big leader on.

So they have someone to call. That's where the lifeline comes in. And so now that the lifeline has that three digit number and is rolling out, we want to make sure that states have the funding to build capacity to answer those calls, that people are trained to respond to those calls and that there aren't wait times. We want to build in mobile crisis units so that people, there are experts, again, social workers, mental health professionals that can respond to those calls if there's a crisis situation that requires intervention and that they have somewhere to go and that's somewhere to go piece has two components. One is crisis stabilization. So while someone may be on a waiting list for mental health treatment in the immediate crisis situation, connecting them to crisis stabilization so they can be stabilized and withstand that waiting period for longer term mental health treatment. That's something we're advocating for.

And then finally, increasing access to mental health services more broadly. Working with people like The Kennedy Forum and others on mental health parity and ensuring that mental healthcare is covered in the same way as physical healthcare and that people have access. So really, 988 has really created this opportunity to build awareness and knowledge that we need to build this holistic continuum of crisis response services. And that's something Project 2025 has stepped into the 988 space a bit as long with our colleagues on our policy team and with NAMI and other organizations in that space. But really it's a huge step forward. But as Nance said, more work to do as well.

Dr. Nance Roy (01:23:39):

Yeah, I would just add, I'm wondering about the question a little bit. I'm wondering if there was some implication about the rollout because I do think there have been challenges with the rollout of 988 in the way that Corbin has described. Not every state has the adequate funding and resources and staffing and so it's a great thing and I have complete faith that it will be fully operational. I think it's spotty state by state. And so, I think we need to have patience and trust that everyone will be able to get on board. One of the positive things about 988 besides its simplicity, is being connected to someone locally that now when you call, you're getting someone in your area code. So far more knowledgeable about resources in your area, in your locale, which is a significant shift from the previous lifeline.

And I would also just mention in addition to the broad scope that Corbin just described in terms of what we need to do to build capacity in a broad way, another, what we find especially for young people, has been a significant tool is crisis text line, that we find so many young people much preferred texting than calling. And even not just young people, but especially young people. So, Crisis Text Line is another excellent service with really well trained volunteers that are supervised by clinical professionals. Again, as what Corbin was saying with 988, if there is something really crisis or acute, they can actually have a licensed clinician responding. So just one more resource.

Teri Brister (01:25:32):

And you are so correct. There are so many people who prefer that method of connecting. So thank you for sharing that. We have several questions that all wrap around the issue of confidentiality or the concept of confidentiality, which is huge, as you both know when you're talking about someone who expresses thoughts or even intentions to harm themself or someone else. One of the comments that came in, and it was from a mother who said, "If I had known that my child was sharing this information with their counselor at school, I might have been able to do something and she might still be here." So curious about what information, what recommendations that you share with schools on when it's not okay to keep a secret, when it is not just okay but necessary to break confidentiality. And in that same vein, if someone in a support group dies by suicide, what suggestions, what thoughts do you have about the therapist discussing that openly with the people in the group? So again, confidentiality's tough.

Dr. Nance Roy (01:26:59):

Yeah, I can take the school one for sure. I'll start with something that's pretty basic and that is every school I know of, both in the high school space and the college space, has students as part of their incoming paperwork fill out an emergency contact form that authorizes the school to contact whoever they designate in the event of an emergency. So I know that feels just like a small thing, but it absolutely is so key When you're in a situation where a student is in an emergency and a suicidality, certainly if someone has an active plan, certainly would constitute an emergency or they get in a terrible car accident or whatever happens. There's many things that can constitute an emergency. So having that thing, however small it may seem, is key. And then a school is in a position to know who has the student given us permission to contact in an emergency.

Dr. Nance Roy (01:28:11):

That's low hanging fruit. I think what becomes far more nuanced is really what the question is getting at. And that is when you're in especially a therapeutic relationship with a young person and they are talking about their issues. Confidentiality has its limits. And when a student expresses harm to self or other significant harm, suicidal, not they're cutting or whatever, but suicide intent or homicidal intent, those in my estimation and in all the schools that we work with, warrant a contact to the emergency contact that's on file. Certainly, students are, if they are entering therapy at a school or a college, one of the first orders of business is to talk through the confidentiality policy and the limits of confidentiality. So we won't tell anybody about X whatever you're talking with me about therapy unless you give me written permission. But when it moves to this level of crisis or emergency, that's when confidentiality could be go by the wayside. So of course we don't know that particular situation for that unfortunate family, but that is the protocol.

Teri Brister (01:29:35):

Corbin, anything you'd like to add to that?

Corbin Standley (01:29:40):

No, I think that about covers it in terms of the support group setting. It is a bit different. I'd say at the outset of support groups, just having an understanding about what's confidential and what's not confidential. But then you also are managing so many emotions and conflicting feelings if a member of a support group dies by suicide. So really both for the facilitator and for the members of that group, it's just about taking a step back and evaluating what they're feeling, recognizing that everything we know about grief, that grief is very individual, however you're processing your grief is valid, and recognizing those feelings and working through that in that way. But it can be incredibly challenging in that setting. So it's just about setting those expectations early on and then navigating that tumultuous grief process that too many of us have been through.

Teri Brister (01:30:43):

Absolutely, and I think we've said multiple times, and it was on a couple of slides, it's complex and it's complicated. And I want to thank both of you for not just your presentations, but for also your responses to what were complex questions. You shared a variety of resources with us and people will be receiving the slide deck, a link to download the slide deck, and I encourage those of you on the call to explore these resources. There's information out there to help professionals. There's information for family members and caregivers. There's information, if you're just an interested community advocate, you're not alone. You don't have to reinvent the wheel. So I encourage you to dig into some of the resources that have been shared and just thank you both so much for the presentation. And Jordan, if you will, go to the next slide please. We want to encourage those of you who are on the call to join us for the next two sessions.

Teri Brister (01:31:48):

This topic is so important and you heard our CEO, Dan Gillison, speak to this initially of he wanted a series done in the month of September, not just one asked the expert presentation, but a series. Coming up September 15th, we have making meaning of suicide loss and on September 22nd, creative approaches to suicide prevention. So again, you've heard some traditional, some replicable interventions that were discussed today, and we're going to hear some other options in these up two upcoming sessions. Most important thing is to remember that you're not alone. The individuals that are going to be in the next two presentations are part of NAMI's new book, you Are Not Alone, The NAMI God to Discovery to Navigating Mental Health, which is totally built on information, advice, suggestions, and lived experience from people who have been there, done that. So I'd also like to give a huge shout out, Oh, let me back up.

The book is available, Jordan, go back to that slide. I forget that it's September. The book is actually available for pre-order now and will be released on the 20th, I believe. So encourage you to go to the website and learn some more about that. And next slide now, Jordan. Huge shout out to the team that makes all of this possible. You see my face, you saw Dan Gillison's face, but there is a team behind the curtain that makes these Ask the Expert presentations happen. Jordan Miller, who is the senior producer for these presentations, Jessica Walthall, Divanna Eckels, Hagen Stauffer have joined us as well, helping us answer your questions on tech issues and also helping us capture your questions to present in the moderation section.

Last but not least, NAMI is a nonprofit organization and we always welcome your donations. The last thing that we want to say about this webinar series itself is make sure that you know it's to transfer information, but it's not intended to provide medical advice on any specific topic. It's absolutely not for a specific individual. In its biggest way, the Ask the Expert series is about sharing information and we again, huge shout out Nance and Corbin for joining us and sharing the information today, and all of the work that both of your organization to do to move this topic forward. So thank you all for joining us, and we hope to see you again next Thursday afternoon for the part two of this series. Thank you everyone.

Dr. Nance Roy (01:34:41):

Thank you.

Corbin Standley (01:34:42):

Thank you.