

# BEHAVIORAL HEALTH NEWS

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ON MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT AND SERVICES

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## In the Shadow of the Pandemic: The Suicide Crisis in America

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The pandemic, overdue confrontations of racism, and fears about the outcome of the 2020 election have diminished America's alarm about rising drug overdose and suicide rates. But these epidemics continue, albeit in the shadow of COVID-19.

This issue of Behavioral Health News is devoted to the crisis of suicide in the first two decades of the 21st century. Over this period, overall suicide rates in the United States have risen by 36.5%, an alarmingly high increase. It is all the more alarming because in the last decade of the 20th century, suicide rates declined by nearly 15%.

Something has happened in the beginning of the 21st century to fuel an epidemic of suicide. What? And what can be done about it?

### Background Information

- Suicide is the 10th leading cause of death in the United States. It is the second



leading cause of death for Americans under 45. The rate of suicide is higher but a less significant cause of death for people over 45, because they are increasingly likely to die of other causes as they age.

- While females attempt suicide far more often than males, males are more than 3 times as likely to complete suicide. This is most likely because males tend to use

guns to take their own lives. Women are more likely to use less lethal means.

- The highest rate of suicide is among males 75+. But the rate for that age group has gone down since the turn of the century, while the rate for working age men has gone significantly up.

- Suicide is more common among White

people than people of color overall, except for Native Americans, who have the highest rate of suicide and the highest increase in rate in this century. Although rates of suicide have increased among Black people, Hispanics, and Asians, they complete suicide at less than half the rate of Whites.

- Suicide is more common, and rising faster, in rural than in urban or suburban areas.

- Guns are the most common means of suicide, especially among men in rural areas. Hanging and drug overdoses are the next most common but are comparatively infrequent.

### The Many Risk Factors of Suicide

There are many risk factors of suicide, including: mental illness, substance abuse, access to guns, chronic physical illness - especially illnesses that are disabling, terminal, and/or involve chronic severe pain, grief, being a victim of ongoing violence, social isolation, homelessness, recent onset of dementia, lack of engaging, satisfying, and/or meaningful activities,

*see The Suicide Crisis on page 29*

## Circle of Grief: Inspires Survivor to Speak Openly About Suicide

By Barbara Felton  
Survivor of a Loved One's Suicide

I walked into the "survivors of suicide" group physically aching and emotionally doubled over in pain. The group - people who'd had a loved one die by suicide - sat in a circle of folding chairs in a pleasant if nondescript meeting room. This was my first visit, a trial effort at relief suggested by friends who'd watched me stumble through a year of grief. The leaders laid out the ground rules for speaking (be sure the person speaking before you is fully finished before you start, do not mention the means of death in your account of what brought you here) and the attendees began to talk.

Rivers of pain poured from the participants' lips. Visible, palpable pain flowed

from the daughter whose father left the dinner table never to sit down with them again, from the husband whose wife waited for him to visit his ailing mother to end her life, from the lover who'd committed himself to death instead of the future of their relationship, from the young man whose brother never came home from college. The room throbbed with grief.

The stories described the variety of losses and, simultaneously, revealed the uniformity of the agony that all those different deaths brought to those left behind. When I'd arrived, I'd imagined that I'd be the most to-be-pitied. It was my son who'd committed suicide, and everyone knew that the death of a child was the worst possible loss. The conviction that I was the winner of this perverse prize, however, crumbled as I heard the others' experiences. To have your parent commit suicide - oh my god - what could be more

devastating to your own sense of worth? To be jilted by a lover through death - could there possibly be a more thorough rejection? To lose a sibling while still so young, when one needed a benign world to look forward to, how could one develop any sort of constructive life plan? All of the experiences described were immeasurably horrible. There was no hierarchy of pain.

People seated throughout the room offered supportive comments as each person spoke, but by and large people presented their stories in the order in which they were seated. Two chairs away from me, a woman in her late twenties shuddered with grief as she told the story of her mother's death. We shook our heads and wept with her. Then her voice grew loud and angry. She'd been advised by the funeral director organizing her mother's funeral to write an obituary for the local paper, a small publi-

cation suitably sized for its small town in upstate New York. When the editor received her carefully constructed obituary, he called to tell her they didn't publish obituaries for people who'd committed suicide. He wouldn't print it. She should use Facebook, he suggested, to notify people of her mother's death.

The room rustled with sympathetic anger. Others began to speak, out of order and loud, and now the stories told of the insults added to the pain of loss. The newspaper editor was one among many: in-laws, friends, immediate family all found ways of conveying the unacceptability of suicide, the wrongness of it, its transgression of the rules of proper society. Don't tell your boss your wife killed herself when you ask for time off, someone's co-worker advised. The messages of

*see Circle of Grief on page 26*



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- Winter 2021 Issue:**  
“Social Determinants of Behavioral Health”  
**Deadline: December 23, 2020**
- Spring 2021 Issue:**  
“Trauma Informed Care and Policy”  
**Deadline: March 18, 2021**
- Summer 2021 Issue:**  
“The Behavioral Health Technology Field”  
**Deadline: June 17, 2021**
- Fall 2021 Issue:**  
“The Behavioral Health Workforce Crisis”  
**Deadline: September 16, 2021**
- Winter 2022 Issue:**  
“Volunteers and the Vital Role They Play”  
**Deadline: December 23, 2021**

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# Suicide Prevention in New York State: We Can Make a Difference But We Need All Hands on Deck!

By Ann Sullivan, MD  
Commissioner  
NYS Office of Mental Health (OMH)

**S**uicide is a public health crisis that demands our collective attention. Over the past two decades, while we have seen major forms of mortality like heart disease, stroke, and cancer decline, suicide rates have steadily increased both in the United States and New York State (NYS). Since 2000 the NYS suicide rate has climbed 40%. Each year, approximately 1700 New Yorkers die by suicide. These individuals are husbands, mothers, sons, sisters, friends, and coworkers. Consider also that each year, New York sees over 20,000 emergency department visits for self-harm; over half a million residents contemplate suicide and the approximately 147 individuals impacted for every 1 suicide and you see the scope of the problem.

**But there is good reason to have hope.** Effective suicide prevention programs exist.

New York State has earned national recognition for its innovative work in suicide prevention and has one of the lowest (49th of 50) suicide rates in the nation (8.3/100,000 in 2018). The [NYS Suicide Prevention Plan](#) rests on three pillars: 1) integrating prevention into health and behavioral healthcare, 2) strengthening public health (non-clinical) prevention approaches at the community level, and 3) continuously improving the quality and timeliness of data used to guide comprehensive suicide prevention. **We all have a role to play in advancing the NYS suicide prevention plan and creating suicide safer health systems, schools, and communities.**

The arrival of COVID-19 has further highlighted the need to strengthen our suicide prevention efforts as well as the need to understand the unique cultural influences that impact the ways in which New Yorkers experience thoughts of suicide and engage with suicide prevention resources. The pandemic has disproportionately impacted communities of color and has exposed frontline workers to great stress. The Centers for Disease Control and Prevention (CDC) published a study



**Dr. Ann Sullivan**

in August outlining increased reports of anxiety, trauma, substance use, and serious thoughts of suicide during April - June 2020 as compared to the same time frame in 2019 (Czeisler 2020). NYS launched the [Emotional Support Helpline](#) in March, for those struggling to manage COVID-related stress and is continuing to support NY residents through Project Hope, targeted to provide support in the communities most impacted by COVID-19. In addition, the NY Cares media campaign is targeted to those suffering the economic impacts of the pandemic. OMH is also supporting suicide prevention training for an expected 6,000 New York City emergency medical personnel, designed to help them recognize distress in colleagues and the public who may be at risk for suicide. Governor Cuomo's Suicide Prevention Task Force [Report](#) published in April 2019 acknowledged the need to consider "the unique cultural and societal factors that impact suicidal behavior" in order to improve programs and resources. Initiatives related to Task Force recommendations and beyond, designed to focus on the perspective and experiences of members of diverse and high-risk communities, have begun. Although inter-

rupted due to the COVID-19 pandemic, OMH is continuing this important work virtually. From meeting with Latina adolescents and parents across the State to examine barriers to treatment and services; experts in the field of Black Youth Suicide Prevention to implement identified strategies, to convening rural suicide prevention experts and community members to focus on meaningful conversations such as "means safety", OMH is committed to continually improving suicide prevention resources available to all New Yorkers. This fall a virtual summit on suicide prevention for veterans, law enforcement, corrections officers, and first responders is taking place and will include public presentations and strategy sessions of experts in suicide prevention from the specific populations.

In NYS' war against suicide, behavioral health (BH) clinicians are frontline, essential workers. Regardless of setting—whether you are working at an inpatient psychiatric unit, community, or outpatient setting—and regardless of your discipline—whether you are a psychiatrist, peer counselor, or another BH practitioner—we all have a role to play in preventing suicide. Unfortunately, too often the training we receive in the assessment and management of suicide risk is inadequate. OMH has surveyed BH clinicians from a variety of settings and disciplines, and the findings are consistent: otherwise knowledgeable and skilled staff often do not feel confident in their ability to assess and manage suicide risk and want more training. To provide BH practitioners with the tools needed, OMH has partnered with the Center for Practice Innovations at the New York State Psychiatric Institute and Columbia University to make a host of best practice trainings in suicide safer care available to BH clinicians in NYS. Suicide safer care should be part of the training curricula for all BH trainees and continue over the course of their careers.

A mainstay of the NYS approach (pillar 1) has been supporting health and behavioral health providers in integrating suicide prevention in their systems of care, often referred to as the Zero Suicide model. It is important to remember that even mental health systems have historically not been designed explicitly to re-

duce suicide deaths. Instead, they have evolved to deliver diagnostically driven services for individuals with mental illnesses, such as depression, bipolar disorder, schizophrenia, and borderline personality disorder, among others. Making that paradigm shift is central to the task at hand. The Zero Suicide model starts with a visible commitment from health system leadership to reduce suicide attempts and deaths among those receiving care, including investments in training clinicians in best practices and data driven quality improvement. The emphasis is moving to a system of care in which suicide safer care is consistently practiced, rather than counting on the heroic efforts of individual clinicians or crisis workers. The Zero Suicide model is both aspirational and practical. Provider systems are asked to systematically screen and assess suicide risk, provide evidence-based interventions, such as safety planning with means reduction, dialectical behavioral therapy, or cognitive therapy for suicide prevention, and to monitor between episodes of care, given the fluid nature of suicide risk.

Delivering high quality, high fidelity care is crucial in the Zero Suicide model. A cross-sectional study of 110 outpatient mental health clinics in NYS, the largest implementation of the Zero Suicide model in the nation, found fewer suicide attempts among clinics reporting greater fidelity to the Zero Suicide model. The literature also suggests that high quality safety plans done collaboratively with patients improve outcomes (reduced suicide attempts and hospitalizations) when compared to those of lower quality. Safety planning is a brief intervention that involves a prioritized list of strategies to help individuals cope with suicidal urges. It is critical to recognize safety planning as an intervention, rather than a form in vacuum. It is one thing for health systems to demonstrate that safety plans are being done with at-risk clients. It is something entirely different to show that those safety plans are being done well.

Transitional care is another essential component of suicide safer care. The immediate post-discharge is known to be a

*see All Hands on Deck on page 33*

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# Suicide Prevention in New York State Schools: Hope and Resilience among Urban, Suburban, and Rural Districts

By Jay Carruthers, MD  
Director, Suicide Prevention Office  
NYS Office of Mental Health (OMH)

New York is a geographically, politically, and culturally diverse state, with nearly 700 school districts serving more than 2.7 million students. Large or small, urban or rural, wealthy or poor, suicide and serious suicidal behavior is a growing concern. Although New York has one of the lowest rates of suicide in the nation, we still lose between 70 and 80 youth to suicide every year, and according to a [report](#) released this month by the Centers for Disease Control and Prevention, the state's suicide rate increased 44 percent from 2007 to 2018 for youth ages 10 to 24. In 2018, more than 1,400 youth ages 10 to 17 were hospitalized for self-harming behaviors and over 4,500 were seen in emergency departments according to the New York State Department of Health.

Though these statistics are concerning, there is good reason for hope. Sound prevention works, and our school communities across New York State are resilient, capable, and well positioned to prevent suicide and promote mental wellbeing. Regardless of size and resources, impactful suicide prevention is obtainable for all schools.

The New York State Office of Mental Health (OMH) and partners have supported schools in urban, suburban, and rural areas across the state to ensure they are equipped to meet the mental health needs of their student bodies. OMH's Children and Families Division oversees school-based mental health clinics and has made improving student access to mental health services a priority, especially when community services are limited. Over the last several years the number of these clinics has doubled to nearly 900, with plans for further expansion. OMH's Suicide Prevention Office and its public health affiliate, the Suicide Prevention Center of New York (SPCNY), have worked to develop and provide education, resources, needs assessments, consultation, and training to school districts across the state, encompassing resources and best practices into a comprehensive [Guide for Suicide Prevention in New York State Schools](#).



Dr. Jay Carruthers

The essential elements of successful school prevention are district and school leadership, community partnerships, and access to and utilization of training and technical assistance. This article provides three disparate examples— from New York City Schools, Town of Webb School District, and North Syracuse Central School District – of these elements at work, including OMH/SPCNY support within demographically, culturally, and geographically diverse student and community populations.

**New York City Schools:** Training school staff in suicide prevention is essential but can be a daunting task for the largest school system in the nation. For several years, SPCNY has worked with the Office of School Health within the New York City Department of Health and Mental Health to ensure all school nurses receive suicide awareness training that includes instruction on the Columbia Suicide Severity Rating Scale (CSSRS) through the Screening The At Risk Student (STARS) program. More recently, twenty individuals were trained and certified as suicide prevention instructors who, in turn, reached more than 1,300 New York City school professionals with suicide preven-

tion programming last year. This year SPCNY will continue to assist in training for a wide array of New York City school staff, including each of the nearly 1,800 suicide prevention liaisons at every school, borough and citywide crisis managers, and ~65 senior school response clinicians who support schools in de-escalation, crisis response, and suicide prevention.

**Town of Webb:** While the New York City School system is the largest in the nation and serves more than 1 million students, Town of Webb School District serves 270 students grades K-12, and 2,000 year-round residents. Located in the central Adirondack region in Old Forge, NY, outdoor sports – including hiking, hunting and snowmobiling – attract tourists who swell the population in the winter and account for high numbers of accidents and fatalities. Most residents are committed to helping visitors and their fellow residents alike, having a police scanner in their homes to aid them as volunteer firefighters, emergency medical technicians, and members of search and rescue teams.

The winter of 2014-15 brought 10 losses including the school's athletic director who died in a skiing accident, the discovery of an alumnus who died in a snowmobile accident by five students during their walk to school, a father in the district who killed himself after struggling with financial difficulties, and a high school student who killed himself over the Thanksgiving holiday. On the first day of school the following year, a recent alumnus died by suicide in a public place. Town of Webb administration reached out for support, contacting neighboring districts, Herkimer Catholic Charities, three local churches, and police and holding parent, student, and faculty meetings. Through this outreach, they found high levels of need, old traumas revived by new traumas, a lack of mental health services with difficulty recruiting and retaining staff, and a general lack of access to medical care.

To address the overall grief from this series of losses, grief support services were provided by Catholic Charities and clergy from three local churches with assistance from other districts in the region. The district also brought in substitute

teachers to have on hand so that teachers could take a break and get emotional support if needed. During the parent meeting, Principal Swick remembers looking out and seeing the distress and concern on their faces. He remembers telling parents, "Look, we don't have answers for this, but we're going to work with you as best we can and together, we'll get this figured out." Little did he know then how the commitment made that night would fundamentally change the school's role in safeguarding the resilience, mental health, and well-being of its community.

Understanding that suicide prevention is a whole community effort and not the responsibility of one organization or one person within an organization, the Herkimer Suicide Prevention Coalition was formed with the assistance of Herkimer Catholic Charities and SPCNY and hosted by the Utica Neighborhood Center. Although it would take a half day to make the long commute to meetings, Superintendent Germer made a commitment to participate in the coalition, making the trip whenever possible. Participation in the coalition reduced the sense of isolation, connecting the school to a larger network of concerned leaders and state and regional resources. Question, Persuade, Refer (QPR) training was also provided at the school, offering participants practical steps to take when concerned that someone in the school community may be at risk for suicide. Principal Swick reflected, "I remember feeling that at least now I know something I can do."

As in many rural communities, Town of Webb recognized how hard it is to recruit and retain mental health professionals and how, for many students, mental health services were one to two hours away, making them nearly inaccessible to many families. With help from OMH and the Neighborhood Center of Utica, a satellite clinic was established on-site at school, offering mental health services not only for students but for adults in the community as well. In the past few years, services have been expanded to include childcare, early childhood education, and after school programming.

While these efforts began in response

*see NYS Schools on page 33*

## How we talk about suicide MATTERS...



"Died of suicide" vs ~~"committed suicide"~~

"Suicide death" vs ~~"successful attempt"~~

"Suicide attempt" vs ~~"unsuccessful attempt"~~

"Working with" vs ~~"dealing with suicidal patients"~~

"Suicide" vs ~~"completed suicide"~~



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# A Personal Journey From a Survivor of Suicide: “From the Depths of Despair to a Mission of Advocacy”

**By Ira Minot, LMSW**  
**Founder and Executive Director**  
**Mental Health News Education, Inc.,**  
**Publisher, Behavioral Health News**

I was drifting in and out of consciousness in the Emergency Room. “You have to drink this,” someone was saying as they held a tall plastic cup to my lips, filled with a tasteless ink-black liquid. I later learned that the charcoal drink was given to me to absorb the toxic soup that was in my stomach after I had taken a handful of pills. I am six-foot six. I have very big hands.

The year was 1996 and I had survived my third failed suicide attempt. I was now on an inpatient psych unit of New York Hospital, Westchester. I had just returned from waiting on line with the other patients during “morning meds.” My doctor entered my room to give me some sobering news on a subject that I knew all too well: “You have a form of serious clinical depression that has not responded to medications over the past several years. If this continues much longer you are headed for a state hospital.”

The notion of ending up in a state hospital gave me a sense of sheer terror—but then, my ten-year illness had destroyed everything I had once taken for granted in my life anyway. I was running out of time and knew my in-patient insurance benefits would be exhausted after this latest hospitalization. I was homeless, destitute and still hopelessly depressed, with nowhere else to go. “We’d like you to consider ECT (electroconvulsive therapy),” my doctor added. “It’s the only thing that hasn’t been tried to help you.”

“What are we waiting for?” I pleaded, “Let’s do it NOW!” I knew very well what ECT was. I had nothing to lose.

Looking back on the ten years of my illness, I kept wondering how this could have happened to me? There were warning signs, but I did not heed them.

Sadly, during my early thirties my mother had lost a courageous three-year battle with cancer, and my own personal life had been severely disrupted by a divorce and the separation from my then seven-year-old son David. Shortly thereafter, I began to experience symptoms of severe anxiety and panic—feelings of such terror and despair that I had never in my life felt before. The year was 1986. I was given a prescription for 100 Valium by a psychiatrist who had never seen me before my calling for an appointment.

Because I had spent years studying about mental illness in college and graduate school, the fact that this was happening to me was quite frightening and bewildering. I was completely at a loss about what



**Ira Minot, LMSW**

to do about it. The Valium did nothing for my symptoms, and as the days passed, I had feelings of such hopelessness and depression that I thought I didn’t deserve to live. I took an overdose of the Valium and was brought to Saint Francis Hospital in Poughkeepsie, New York where I was living and working at the time. I was given a diagnosis of severe reactive depression, which is not uncommon following the death of a parent, a divorce, and their disruption to one’s emotional state. I stayed in the hospital for a few days and was sent home with some new medications.

Because I had my current fundraising position to worry about, I proceeded with the conviction that this was simply a passing “blip” on the timeline of my life that would be over in short order. That “blip” lasted for ten years.

I was embarrassed and ashamed of my condition which was an additional tragedy to endure on top of my illness. I was learning about *stigma* towards people with mental illness firsthand, and I received a full dose of it from friends, family and employers alike.

I had no clue about caring for my illness. Nobody seemed to have a handbook to give me with the proper directions to take. With a quickly acquired dislike for their side-effects and an uninformed regard for staying on the myriad of medications that were being thrown at me every six months, I continued on a downward spiral. I was watching as my life was being destroyed before my eyes. I was placed in outpatient treatment programs with only short periods of wellness and longer and more pronounced periods of devastating depression.

Looking back, it was just before I entered the MSW program at NYU that I

worked at New York Hospital in Westchester. Now, twenty years later, I was hopelessly ill and a patient at the very same hospital. While working there as a young psychiatric aide, one of our duties was to escort patients to the ECT lab and monitor their vital signs during the procedure. I had seen it work miracles on patients who were deemed hopeless in treatment.

I was now on the very same ECT Lab table hoping the procedure would save my own life. How unbelievable and ironic. Thankfully, in my case, the full course of ECT treatments I received broke the chains of my depression and brought me back to life. Fortunately, I did not have any memory loss from my ECT.

Some months later with my depression lifting, I tried to make sense of my ten-year battle. I knew there were mistakes I (and others) had made in my care and treatment. I became angry that my life had been put in such peril and realized that I was lucky to be alive. My own lack of mental health education caused me to take chances with starting and stopping the medications I was being given during my illness. More disturbingly, the treatment teams that cared for me during my illness never made me aware of the other valuable and vital resources within the mental health community that had been available to me during my ten-year illness.

I was never told that there was a vital Mental Health Association (MHA) in the community, or that there was a group called NAMI (The National Alliance for Mental Illness) that provided education and support for family members. I was never told there were drop-in centers and clubhouses that were run by people with mental illness to help others with the same psychiatric illnesses. I would have truly benefited by knowing about and participating in such programs.

Had the people who treated me over the years not been trained to understand the need for a community-wide approach to a person’s mental health recovery? Maybe I was just too valuable a commodity to them, and they were afraid they would lose me to another service provider? I hate to think that *that* might have been the reason.

I realized that there was a *critical gap* in the recovery model of our mental health system. There were no readily available and up-to-date journals of information and education for individuals and families on the nature of mental illnesses, treatment options, coping strategies, community resources and support systems that could be regularly sent directly to those who need it most. Sadly, outside of the few hours a day that I and other patients were involved in treatment, nobody had found a way to reach us where we lived. It

was sad to think that patients were going home to a lonely apartment where they were isolated and highly vulnerable, as I had been. In addition, most families were at a loss as to what to do and where to go for help for their loved ones.

I knew this was wrong and set out to change the way people learn about mental illness and our mental health community. I imagined that this lack of mental health education probably existed in communities near and far, and that the community would welcome a solution. I was right.

I set out to fill this need and with the help of many wonderful leaders of the mental health community created a quarterly newspaper in 1999 called *Mental Health News*, which in 2013 became *Behavioral Health News*. *Behavioral Health News* now reaches out to people struggling with substance use disorders as well as mental illness. For over 20 years, *Behavioral Health News* has grown to be an award-winning publication which today has a nationwide print, online, and social media readership of over 200,000 individuals, families, treatment professionals and service providers.

In the Fall of 2008, we premiered a new publication called *Autism Spectrum News* to provide vital science-based news, information and resources to the rapidly growing autism community. In the award-winning tradition of our organization, *Autism Spectrum News* has become a must-read for families, consumers, treatment professionals and service providers throughout the autism community.

My greatest joy came when my son David Minot joined me as my Associate Director and publisher of *Autism Spectrum News*. David grew up in the extremely difficult shadow of my ten-year battle with mental illness. To know that he now shares my vision to provide mental health and autism education to the community is truly a story of our survival, and provides hope to many people who are traveling the same difficult road that David and I traveled together so many years ago.

And me? I guess you could say that I have gone “*From the Depths of Despair to a Mission of Advocacy*.” Incredibly, my life is fuller now than it ever was before my illness began. I take great pride in knowing that we are providing a means to help people find their way through the difficult maze of mental illness and autism spectrum disorders, and that we are succeeding in our mission to give our mental health and autism community *the recognition they deserve*.

**Good luck in your recovery and always remember to never give up, no matter what difficulties you may face.**



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# COVID-19 PANDEMIC: A NEW OPPORTUNITY FOR TELEMENTAL HEALTH



The COVID-19 pandemic has drastically changed the way behavioral healthcare is delivered—interactions between providers and clients shifted from in-person to telephonic/audio-visual means of engagement and service delivery. The temporary regulatory changes that were enacted at the federal and state level enabled this transition to new modalities of virtual care that proved critical for the continuity of care for many of New York’s most vulnerable individuals.

Coordinated Behavioral Care’s [Telemental Health Position paper](#) is informed by our relationship with over fifty community-based health and human service organizations throughout NYC serving more than 100,000 Medicaid clients.

## COORDINATED BEHAVIORAL CARE IS ADVOCATING FOR:

### 1. PERMANENT REGULATORY RELIEF FOR TELEMENTAL HEALTH

As a result of the COVID-19 pandemic, substantial regulatory relief was extended to providers by both local and national governing bodies. Providers and telehealth vendors have worked together to deliver safe and effective care, setting the stage for a new and more expansive service delivery methodology. CBC recommends the formal adoption of many of these regulatory waivers, such as expanded location of service, use of audio-only interactions and increased provider/client choice.

### 2. ADMINISTRATIVE FLEXIBILITIES FOR TELEMENTAL HEALTH

Administrative and workflow flexibility have, in the short-term, yielded promising results and warrant consideration for permanent adoption. Examples of promising temporary workflows include streamlining documentation requirements and reducing redundant or obstructive confidentiality requirements. These flexibilities have been especially essential for the population struggling with substance use disorder/opioid use disorder (SUD/ODU) during the pandemic.

### 3. ENHANCE WORKFORCE CAPACITY

As a result of relaxed workforce requirements, providers have been able to meet the needs of clients in a responsive manner during the pandemic. CBC recommends the relevant guidelines be made permanent, including those allowing providers licensed in New York but living out-of-state to offer telemental health services remotely. If a client is having difficulty with “technical literacy” that may prevent treatment engagement, BH providers should be able to support them and include this as billable time.

### 4. EQUITABLE PAYMENT/RATES

Telehealth has been shown to increase access and adherence to care through a combination of reduced barriers (like travel) and practice management tools (like appointment reminders). CBC recommends leveraging technology to promote more reliable and effective engagement efforts, as the sector shifts from fee-for-service (FFS) payment models to ones that focus on outcomes. Until such models are determined, CBC recommends that parity in payment and rates for services remain and that telehealth is reimbursed at the same rate as in-person treatment.

## ABOUT CBC

[Coordinated Behavioral Care \(CBC\)](#) is a member-led, not-for-profit organization dedicated to improving the quality of care for New Yorkers with serious mental illness, chronic health conditions and/or substance use disorders. CBC seeks to create a healthcare environment where New Yorkers negatively impacted by social determinants of health and those with BH problems receive coordinated, individualized and culturally competent community-based care that is effective in preventing and managing chronic physical and BH conditions.

# Challenges and Solutions: Mental Health Responses During COVID-19

By David Kamnitzer, LCSW,  
Chief Clinical Officer and Mindy Liss,  
VP for Strategic Communications  
ICL

**D**uring the most challenging times, even in the face of an unprecedented crisis — ICL seeks to implement strengths-based approaches to helping people cope and eventually to thrive once again. This holds true whether a person is living with a childhood trauma, substance abuse, suicidal thoughts or the most daunting circumstances such as those brought by the COVID-19 pandemic.

Beyond the great physical toll the past few months have taken, the ravages of COVID-19 have had significant effect on the mental health of communities throughout America. That of course came as no surprise. Millions of people lost a family member or loved one and were prevented from saying goodbye. Those who survived the virus experienced frightening symptoms they will not easily forget. Unemployment reached levels most of us have never seen in our lifetime; workers in whole sectors of our economy now face uncertain futures. Wall-to-wall news coverage of the pandemic is triggering for trauma survivors.

And the number one instruction for dealing with the virus meant physically isolating ourselves, robbing us of one of our best coping mechanisms, the company of others. This forced many to face these enormous challenges alone. For those living with mental illness and substance issues, like most of the 10,000 people ICL helps each year, though isolation was already their everyday experience, following stay-in-place orders further stigmatized them.

Last month, the Centers for Disease Control and Prevention released a study done in June that revealed that 40% of American adults were struggling with mental health or substance use issues.



David Kamnitzer, LCSW

This included 25.5 % who reported symptoms of anxiety disorder (compared to 8.1 % in the same period in 2019) and 24.3 % with depressive disorders compared with 6.5 % the prior year. The study further showed that 13 % of those surveyed began or increased substance use and 11 % seriously considered suicide. The latter number was especially shocking and challenged mental health systems already limited and pulled in many directions because of COVID-19.

As we reflect on the mental health challenges faced in the past six months and the likely growing mental health crisis on the horizon, there has never been a more important time to shed light on how we are responding, particular to mitigate the rise in suicide and suicidal ideations. In the best of times, this is a topic too painful to discuss because more than any other area of mental health, suicide remains a highly stigmatized and taboo



Mindy Liss

topic. Though it could be more easily overlooked during a worldwide health crisis, as health care providers, we know the subject has to be confronted head on. And the fact that September is designated as National Suicide Awareness Prevention month provides more impetus and information to help us confront this difficult topic. Given the increase in suicides and suicidal ideation during the pandemic means we must not only openly discuss this subject but we have to make information readily available and advocate for reforms that will save lives. Most of all, it is our responsibility to let people know that it is okay to talk about this subject, in fact it is essential.

Given the increase in suicides and suicidal ideation during the pandemic means we must not only openly discuss this subject but we have to make information readily available and advocate for reforms that will save lives. Most of all, it is our

responsibility to let people know that it is okay to talk about this subject, in fact it is essential.

At ICL, we serve 10,000 New Yorkers each year in more than 100 programs across the five boroughs. The people we see each and every day are living with mental illness and substance use disorders; many are families in crisis. While no one is immune from the emotional dimensions of the pandemic, the populations we work with have been particularly vulnerable to a tremendous exacerbation of their mental health struggles. Bringing help and support to this population had to be done quickly but also very carefully.

At ICL, we have standing protocols widely disseminated to our staff when someone at risk for suicide comes through our doors. Agency clinicians immediately put into place risk assessment and all of our risk management protocols that start with immediate access to psychiatry services. Strength-based treatment such as dialectical behavior therapy (DBT) and cognitive behavioral therapy (CBT), offer hands-on, practical approaches to problem-solving aimed at changing patterns of thinking or behavior. We also put a safety plan in place to be able to respond quickly if something goes wrong and continue to assess the risk to the client until they are out of danger.

ICL is also benefiting from the work being advanced by the Zero Suicide for Healthcare organization including evidence-based practices for screening, assessment, direct treatment and collaborative safety planning.

In some respects, the pandemic afforded us new opportunities to make services more accessible to those at highest risk, including those showing suicidal ideations. At the onset of the pandemic, our agency went into high gear to reach out to the community and make services as accessible as possible. Since getting the most at-risk to access help is difficult to

*see Solutions on page 32*

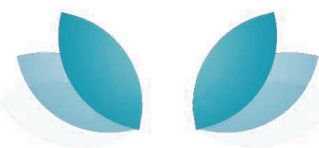


People Get Better With Us

## Coping with COVID-19

## CONDUCTING THE TELEHEALTH SESSION

Life has changed dramatically for all of us since the emergence of COVID-19. To continue serving the most vulnerable people during this very challenging time, ICL has shifted services to telehealth sessions – by phone or video – wherever possible.

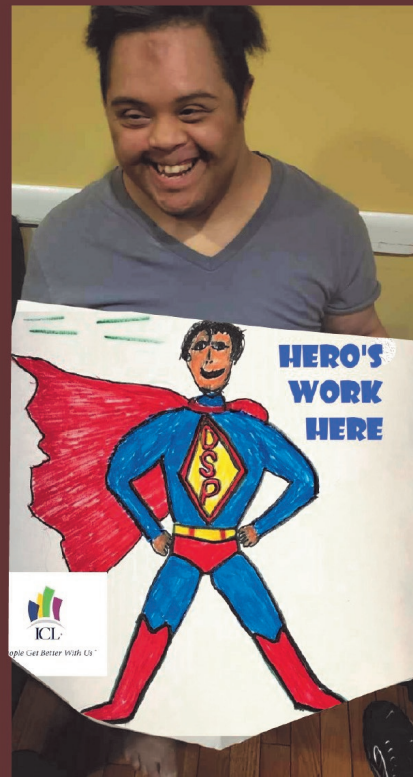


*“Like many agencies, COVID-19 forced us to shift service gears, ICL quickly implemented telehealth services and produced a booklet of tips and strategies. Telehealth treatment proved to be very effective in addressing issues like suicide and other moments of crisis. A vast majority of our clients surveyed said they would prefer to stay in telehealth treatment.”*



*People Get Better With Us*

The Institute for Community Living is grateful to all our staff for responding to the extraordinary challenges of COVID-19 with your usual skill and determination. You helped keep all our services open and everyone who needed our help got it.



Thank you for ensuring the health and well-being of all New Yorkers.  
Each of you is an ICL star!

To learn how we are changing lives, visit [www.iclinc.org](http://www.iclinc.org)

# Faith Communities Perspective and Role in Suicide Prevention

**By Max Banilivy, PhD**  
**Director of Clinical Training,**  
**Education and Field Placement Services**  
**WellLife**

**A**t a time when the suicide rates continue to increase and more lives are lost every day, it is prudent to create more awareness among the many gatekeepers and stakeholders in the community. One of the more prominent among them are CLERGY and the many different communities they serve—focusing on SAVING SOULS and matters of LIFE and DEATH.

The loss of at least 48,000 Americans every year (all estimates are underestimations), including youth and young adults who are known to have killed themselves is beyond tragic. This is particularly noteworthy as suicide is one of the more preventable causes of death. In addition to the loss of these lives, millions are directly traumatized and become survivors as families and friends. As concerning as these numbers are there are also the many times (perhaps 25 times) that individuals try to kill themselves, being left with painful LIVED experience with suicide. We will probably never know how many among us have thought about suicide and attempted to kill ourselves without anyone finding out. These individuals continue to live with their despair and pain among us and in most situations let the rest know in direct and indirect ways that their life may be in danger. Estimates are that perhaps one out of every 20 community members may have or is thinking about SUICIDE. These profound numbers speak to an opportunity on all of our part to learn and know about conversations to have and resources for those with thoughts of suicide.

## Clergy and Faith Communities Lead the Way in the Prevention of Suicide

At the forefront of the list of stakeholders for suicide prevention are CLERGY and their respective FAITH COMMUNITIES. In a recent observational study by Harvard published by JAMA Psychiatry, May 6, 2020, it was reported that “Faith-based organizations promote social engagement and connectedness and preach against self-injury and substance use.” This suggests that faith



**Max Banilivy, PhD**

and the individuals and communities involved potentially serve an important protective factor against suicide. A model adapted from Thomas Joiner explains why people die by suicide. There is high risk for completing suicide where at least a few factors are present: Perceived Burden, Thwarted Belongingness, and Acquired Capacity for Suicide.

This clearly highlights the value for belongingness that faith communities offer. This is some indication that affiliation and some attendance at religious services may buffer to some extent the pain, despair and helplessness/hopelessness in individuals with their uncertainty and ambivalence about ending their lives. This is where baseline education and continuing best practice education for members of the clergy is a MUST as they are in a unique position in terms of their education and position to be a unique member of the universal efforts for suicide prevention.

In order to expand on and discuss the role that clergy and faith communities serve in the mission of suicide prevention, it is important to briefly summarize the religion's point of view. According to Minister Willie Scott, VP of Public Affairs for WellLife Network (WLN), “Christianity, Judaism, Hinduism, Islam and Buddhism do not condone suicide. Suicide is viewed as a lack of faith, in God's ability to deliver you from your suffering or whatever the issue is that drives you to suicide”. There are common themes shared by all the major religions reported by the Suicide Prevention Resource Center (SPRC.org).

## Suicides May Be Prevented

All faith groups have a strong reverence for life. Having said that there is a wide range of ideas, beliefs and opinions about suicide. As stated above except for the concept of: “honorable” suicide in Hinduism, no faith group condones it. As we are considered to be responsible for each other, suicides can be prevented. Suicide is a tragic loss that victimizes and continuously creates an ever-increasing group of survivors whose suffering in many cases just starts by this profound loss. The multi-determined and multi-dimensional nature of suicides makes them complex and many survivors are left with so many unanswered questions. Many myths and stigmas still exist in all communities that prevent so many from seeking and receiving culturally sensitive care. Limitations in best practice language, resources and treatment have and continue to be a serious obstacle. Clergy and religious organizations are or would welcome participation in suicide prevention efforts.

According to Minister Scott, “Due to economic situations, Coronavirus, maintaining a family, and the daily pressures, of life, many members of the clergy discuss suicide, while preaching and in counseling sessions, with members of the communities.”

## Postvention Is Prevention

What are some of the concepts and points for clergy and faith community leaders to keep in mind. Every faith leader should explore and have a clear understanding of how/why suicide prevention centrally fits in their role. Knowing how to reach out to community members in a non-stigmatizing and inviting manner being clear as to how the views of a particular religion may not be facilitative. Being aware of what thousands in the communities are looking for which is a non-judgmental ear to listen to their pain and what brought them to this point to begin with. Identifying those who may have thoughts of suicide in a non-stereotypic manner. Sadly, suicides continue to happen and are increasing. These individuals are listening as to how suicide is spoken about and where they can connect with caring and compassionate persons with comfort and without fear. Additionally, given the realities of current life

circumstances, it is prudent that faith leaders are well trained in the POSTVENTION. POSTVENTION IS PREVENTION. However, according to Minister Scott “Many members of the clergy are not trained in Postvention.” This is a serious vacuum.

The faith leaders have many opportunities to prevent suicides as they are routinely in interaction with individuals with thoughts of suicide and may not know it. Preaching with open and direct conversation about suicide is fundamental to the mission of suicide prevention. Best Practice teaching and training for the leaders and the faith communities is an integral part of the community-based approach. Community discussions about prevention, intervention and resources, as well as preparedness with fundamentals of postvention in an organized manner are recommended. Additionally, continued interfaith discussions to share knowledge, and build strategy should be a building block.

WellLife Network welcomes you as a leader in suicide prevention, intervention and postvention to participate and engage in an initial discussion and develop a committee within your community/organization to organize and have a planned approach to suicide prevention. No better time than this coming month. September 10th of each year is WORLD SUICIDE PREVENTION DAY and the week of National Suicide Prevention. You are invited to plan an activity, training, informational session, in recognition and most importantly to convey the message that SUICIDE IS PREVENTABLE. Remember most who are thinking about suicide are uncertain about ending their lives.

**IF YOU ARE CONCERNED ABOUT SOMEONE, ASK THEM IF THEY HAVE THOUGHTS OF KILLING THEMSELVES. YOU WILL BE SURPRISED HOW MANY MAY SAY YES AND WILL BE GRATEFUL THAT YOU ASKED.**

The following number and website among others to national and local crisis hotlines and resources should be readily visible and available to everyone: 1-800-273-TALK (8255) or 1-800-273-8255 Preventsuicideny.org

*For further information and consultation contact: Mansour (Max) Banilivy, PhD at [max.banilivy@welllifenetwork.org](mailto:max.banilivy@welllifenetwork.org).*



**Contact: Anne G. Katz**

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# Socially Connected, Physically Distanced: How to Be There for Someone Experiencing Suicidal or Emotional Crisis During COVID-19

By John Draper, PhD  
Executive Director, National Suicide Prevention Lifeline and Executive Vice President of National Networks, Vibrant Emotional Health

While everyone is feeling challenged during COVID-19, it can be particularly difficult for those with existing mental health conditions or people who feel particularly lonely or isolated due to COVID-19. “Social distancing” recommendations, concerns about their own health and the health of loved ones, and the disruptions to services and everyday life, can increase levels of anxiety and distress. We prefer to use the term “physical distancing,” so we can underscore that social disconnection is in no way advisable in this public health crisis. In fact, socially connecting with others preserves mental health and resilience, and is essential for overall health during this stressful time when people cannot enjoy physically congregating in ways that were routine prior to the pandemic.

At this time, we do not have any evidence that shows greater physical distancing is resulting in higher suicide rates. Nevertheless, U.S. national surveys are indicating that more people are feeling



John Draper, PhD

stress, anxiety and depression, and more are reporting thoughts of suicide when compared to this same time last year. As a result, we all need to be prepared to help ourselves and others cope through this challenging time. Some warning signs may help you determine if you are a loved one is at risk for suicide, especially if the behavior is new, has increased, or seems

related to a painful event, loss, or change. Discerning these warning signs in others while maintaining physical distancing isn’t easy, so it may help to ask them and those who are living with them about these signs if you have some concerns about how they may be feeling, thinking or acting. Here are some (physically distant) behavior patterns that could suggest that you or someone you care about could be in emotional distress:

- Changes in tone, language, or time of day when texting, talking, or posting online
- Ignoring calls or texts;
- Changes in the frequency (more or less) and content of what they might be sharing online or if they share media links with you;
- Intentionally withdrawing socially because of a lack of belonging, fear, hurt, or perceived social rejection (not to be confused with maintaining physical distancing recommendations);
- Posting online or talking about feeling trapped, hopeless, a burden to others, or being in unbearable pain.

In addition, noticeable physical changes may be a reason to check in, such as:

- significant change in energy level or appetite;
- increased use of drugs or alcohol;
- extreme mood swings;
- sleeping too much or too little;
- frequent headaches, stomachaches, or body pains;
- heightened worrying or anxiety; or
- inability to take pleasure in activities that were once enjoyable.

If you're concerned about someone in your life that may be in suicidal crisis, Vibrant Emotional Health, administrators of the National Suicide Prevention Lifeline, have created five steps to help. The five **#BeThe1To** steps are simple actions everyone can take to help reduce emotional distress and potentially prevent suicide. These steps are derived from research and applied training for crisis counselors in the Lifeline network, and provide some very basic, fundamental tips about caring for others who are in crisis. During National Suicide Prevention Month

*see How to Be There on page 34*

## Suicide Prevention Month Interview with Dr. John Draper by Dr. Richard Juman



### Physical Distance ≠ Social Isolation Social Connection is more important than ever

Public health events and infectious disease outbreaks, such as COVID-19, can cause emotional distress and anxiety. These feelings can occur even if you are not at high risk of getting sick.

Many of the signs that someone may be considering suicide will be harder to read during times of physical distancing.

The **#BeThe1To** steps can be adjusted for staying connected during physical distancing.

**ASK - BE THERE - KEEP THEM SAFE - HELP THEM CONNECT - FOLLOW UP**

For tips on how to stay connected during times of physical distancing, visit



[www.bethe1to.org](http://www.bethe1to.org)





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# The NYSPA Report: Veteran Suicide - The Challenging Epidemic

By Marianne Goodman, MD,  
Richard Gallo, and Jamie Papapetros

**W**hile COVID-19 information dominates the news cycles, another epidemic lurks in the shadows - suicide. Death by suicide is a shocking and disturbing event, increasing in number despite nationwide efforts and attention. While humans are the only species known to take their own life, there is growing consensus that suicide death can be prevented and multiple organizations, foundations, government entities at local, state and national levels are teaming up to do so.

One hundred thirty-two people in the United States die by suicide every day and approximately one every 11.3 minutes, totaling over 48,344 suicide deaths in 2018, the last year for which statistics are available (American Foundation for Suicide Prevention/Centers for Disease Control and Prevention (CDC) Data & Statistics Fatal Injury Report for 2018). The number of suicide deaths has been rising over the past decade. From 2005 to 2017, there was a 43.6% increase in the number of suicide deaths (Department of Veterans Affairs, 2019) propelling suicide into the list of top ten causes of death, just behind influenza/pneumonia, diabetes and kidney disease (CDC, 2019). An important subgroup at particularly high risk is Veterans.

## The Veteran Suicide Problem

Although the 20 million U.S. Veterans comprise only 7.9% of the U.S. population, they account for approximately 13.5% of all suicide deaths among individuals (Department of Veterans Affairs, 2019). Moreover, the Veteran suicide rate was 1.5 times that of non-Veteran adults even after adjusting for age and sex (Department of Veterans Affairs, 2019). In stark contrast to civilian suicide death rates which are highest in individuals 45-65, younger Veterans aged 18-29 are most



Marianne Goodman, MD

impacted. However, suicide counts are greatest for Vietnam-era Veterans. Female Veterans too are showing concerning increases in suicide death rates that greatly outstrip their civilian counterparts. New York is not immune as 136 Veterans died by suicide in 2017 with the rate doubling between 2005 and 2017 for Veterans between the ages of 18 and 34 (NY Health Foundation, 2020). Elevated Veteran suicide death is best understood due to several factors including combat exposure, heightened levels of post-traumatic stress disorder, difficulties with readjustment to civilian life and access to lethal means, in particular firearms. Suicide death by guns is particularly relevant for Veterans, as guns account for 71% of Veteran suicide deaths, and guns at home triple the risk of suicide death (Department of Veterans Affairs, 2019). In New York State, 46% of all Veteran suicides were by firearms, underscoring the importance of addressing gun safety in Veteran (and civilian) suicide prevention efforts. Additional factors that convey suicide risk in Veterans include homelessness, involvement

with the penal system, economic stressors including unemployment and poverty, comorbid medical and psychiatric conditions (particularly those that involve pain), and gaps in social connection.

Complicating Veteran suicide prevention efforts is the fact that approximately 70% of Veterans do not use Veterans Health Administration (VHA) services, and over 60% of Veteran suicide deaths occur among those who have not received VHA services within the past 2 years (VA, 2019). The Veterans Choice Act and now the MISSION Act have increased the opportunity for Veterans to seek care from providers in the community based upon certain criteria. Therefore, enlisting our colleagues in non-VA settings is critical to reducing Veteran suicide as the VA alone cannot solve this problem and building community partnerships is now a top priority.

While community partners and clinicians outside of the VA system see the majority of Veterans, a recent RAND study (Tanielian, et al. 2018) found that only about 2 percent of New York State community physicians and other health care providers are prepared to provide quality care to Veterans. The other 98% were ill equipped on many of the seven measures of readiness; most notably familiarity with the military culture and performing routine screens for conditions common among Veterans. These data underscore the need for provider training in these areas.

## Specific Strategies to Target Veteran Suicide Prevention

**Asking your Patient - are you a Veteran?** Many civilian providers are not aware of Veteran status for their patients because many intake forms do not request this information. This is easily fixed by asking each patient whether they ever served in the military.

Once this information is gleaned, further interview questions pertaining to combat exposure, military sexual trauma

and other trauma exposures, discharge status, current gun possession, and any service-related injuries can be discussed. Pay particular attention to aspects of the patient interview pertaining to combat exposure, drug and alcohol use, firearm access, readjustment difficulties and fear of stigma for seeking help; health and pain problems; all of which heighten suicide risk. Protective factors include supportive families, Veteran peer support, appropriate storage and management of weaponry, engagement in treatment for war related PTSD or Depressive illnesses.

**Increasing your Knowledge Base about Veteran Suicide and Veteran Issues.** Consider participating in the New York State Psychiatric Association's (NYSPA) Veterans Mental Health – Primary Care Training Initiative (VMH-PCTI). NYSPA's VMH-PCTI has developed a series of lectures and webinars for primary care physicians and related specialists on the signs, symptoms, and best practices for Veteran-specific mental health issues including combat/military-service related post-traumatic stress disorder, traumatic brain injury and other conditions, including suicide and substance use disorders. The current presentations, accessible through the NYSPA website ([www.nyspsych.org](http://www.nyspsych.org)), are entitled: (i) Invisible Wounds of War: Post-Traumatic Stress Disorder, Traumatic Brain Injury & Combat-Related Mental Health Issues and (ii) Recognition, Management and Prevention of Veteran Suicide.

NYSPA's VMH-PCTI also worked with subject matter experts to develop two additional presentations: (i) a one hour presentation on military culture developed by Joe Geraci, PhD and retired US Army Lieutenant Colonel, a widely recognized authority in the State and nation on military cultural competency and Veteran identity and (ii) a one hour presentation on women Veterans developed by Meaghan Mobbs, M.A., West Point graduate, Afghanistan Veteran, former

see *Veteran Suicide* on page 30



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## Rising to the COVID-19 Challenge

By Peter Provet, PhD  
President and CEO  
Odyssey House

When Governor Cuomo ordered the closure of non-essential businesses across New York State in response to rising coronavirus infection rates, Odyssey House stayed open.

Our essential residential treatment centers, outpatient services, supportive housing apartments, and primary health clinics in East Harlem and the South Bronx are located in some of the most socially and economically disadvantaged neighborhoods in NYC. These communities, already suffering from health disparities of social injustice and equity, were hit hard by a highly infectious and deadly virus that overwhelmed local social service providers and brought tragedy to many families. **We couldn't, and we wouldn't, close our doors in a time of such urgent needs.**

With just a few weeks to prepare for this unprecedented public health crisis, we moved quickly to introduce procedures that limited the risk of infection in our facilities, maintained essential treatment and housing services, and shifted administrative systems to remote functions.

These early measures not only kept the doors open for the vulnerable populations



Peter Provet, PhD

we treat, but they also helped keep our employees as safe as possible while they carried out essential services.

It was not only staff who worked together to keep services running; clients also pitched in to keep each other safe. Residents in substance abuse treatment centers with hundreds of beds quickly adopted new behaviors that ranged from keeping physically distant, wearing masks, increasing handwashing and other sanitation protocols, to accepting limits on visits and outside travel. And for people with serious mental health challenges living in our supportive housing facilities, helping

them incorporate new health guidelines became a life or death priority.

**Ready to meet increasing needs:** The long-term impact of the coronavirus on the health and well-being of New Yorkers is still unfolding. Fears that a second, or more, wave of infection will return, that the economy will take a long time to recover, and that substance abuse and other mental and physical health problems will increase are very real. Government leaders warn of significant cuts to services and urge all Americans to prepare for difficult times ahead while we rebuild from this public health crisis.

Those of us who work in the behavioral health field know that social disruption on this scale is likely to fall hardest on the underserved people we care for. Research studies warn of increased substance misuse, overdose deaths, and suicides with young adults and racial minorities among those disproportionately affected.

In August, The Centers for Disease Control and Prevention (CDC) released its [Morbidity and Mortality Weekly Report](#) - the results of a survey of 5,412 adults taken in late June - that showed 41% reporting at least one adverse mental or behavioral health condition. Those conditions include symptoms of anxiety, depression, and increased substance use to cope with stress or emotions related to COVID-19.

The researchers also found that nearly

11% reported having seriously considered suicide in the 30 days before completing the survey, compared with about 4% in a 2018 survey who said they'd considered suicide in the past 12 months. The worrying CDC data also found that certain groups were shown to be even more susceptible to suicide: 25.5% of young adults, aged 18 to 24; 30.7% of self-reported unpaid caregivers for adults; 21.7% of essential workers; as well as racial minorities — 18.6% of Hispanic respondents and 15.1% of Black respondents.

**COVID-19 must not stall progress on the opioid epidemic:** We are doing all we can at Odyssey House to prepare for increased demands on our services and we will not turn anyone away who comes to us for help. We were starting to make a dent in the opioid epidemic and are concerned that the coronavirus pandemic will undermine that progress and exacerbate the health risks in our communities.

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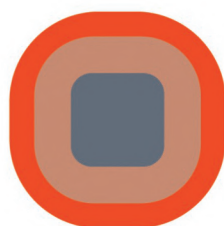
Before the pandemic hit, suicide and drug overdoses had been a growing concern among health professionals.

*see COVID-19 Challenge on page 34*

Learn more about our integrated behavioral health and supportive services for individuals and families coping with substance misuse, mental illness, and homelessness.

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# Personalized Recovery-Oriented Services in the Era of Social Distancing

By Alicia Lore-Grachan, LCSW, and  
Alice Sorensen, LCAT, MT-BC,  
The Guidance Center of Westchester

**P**ersonalized Recovery-Oriented Services (PROS) is a program which evolves around increased socialization, togetherness, and connections. Our group classes at The Guidance Center of Westchester (TGCW) are lively, and our participants thrive in an environment where they learn and gain support from one another as well as from the professional staff. PROS is very much a community.

COVID-19 threw a curve into our PROS paradigm. Yet, our staff and participants adapted and overcame obstacles. Even in these trying times, our participants continue to work toward recovery, and we are seeing positive results.

Like so many other mental health programs, we needed to move to virtual or online courses. While we had some trial and error, we quickly reached an effective way to meet the needs of our participants. We are so proud of the adaptability of our program participants and staff.

We continued to meet in person with participants the week of March 16. During that time, we prepared by creating individual telehealth schedule for each participant. We helped participants download applications, such as Zoom, and taught



**Alicia Lore-Grachan, LCSW**

them how to use them. We provided participants with resources on where to obtain food and how to follow CDC health guidelines for safety.

The week of March 23, we began the individual telehealth schedules. Meeting individually with each participant via telehealth twice a week proved overwhelming to staff and participants alike. Participants missed interacting with others. It was



**Alice Sorensen, LCAT, MT-BC**

clear that in order to provide adequate support for participants, we would need to move telehealth classes. By the end of that week, we developed a modified schedule and structured curriculum for our virtual classroom.

We began Zoom classes on March 30. Participants were very excited and found comfort in being able to see their peers. By April 6, we had more than 70 courses

of 40-minutes running each week. We fine-tuned the schedule and offerings, making sure we were providing participants with content they wanted. By April 13 we were offering 75 courses of 45 minutes each. Much like in the “old” days, participants are able to choose which courses they want to participate in throughout the day.

“I really appreciate the PROS staff for continuing to conduct groups by telehealth because the groups really help me stay focused,” said one participant.

We’re offering new courses such as staying safe and well during the pandemic and social distancing. We’ve modified some of our “tried and true” courses to fit the new model. These include peer support, mindfulness, gardening, physical fitness and eating healthy with what is in your cabinet. Our “music to our ears” course allows participants to share music that they find uplifting, and our music therapy explores writing lyrics and incorporates household items as instruments.

Another PROS participant said the following: “I usually isolate in my apartment and it is hard for me to go into program and then get the strength to attend groups. Now with telehealth I feel less lonely in my struggle because everyone has to isolate. At the same time I am

*see PROS on page 26*

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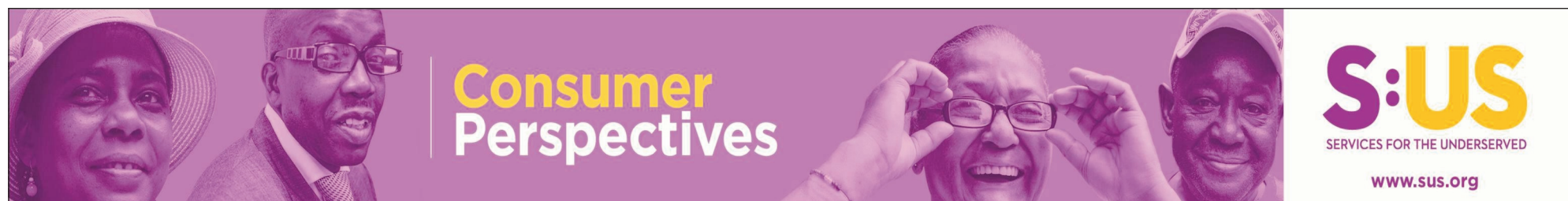
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## Preventing Suicide During the Pandemic

**By Anthony**  
**A Client Served by**  
**Services for the Underserved (S:US)**

**T**his article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The author is served by Services for the Underserved (S:US), a New York City-based nonprofit that is committed to giving every New Yorker the tools that they can use to lead a life of purpose.

I am a 50-year-old African American man who has been living in S:US supported housing since November 2015. I have had a lot of difficulty in the last few months struggling with the pandemic and family issues but knowing that I have a place to call my own and I am no longer in prison keeps me hopeful. I am so grateful to S:US for providing me with the services and care that were not available to me when I lived in a shelter.

I've come to learn that S:US supports

thousands of vulnerable New Yorkers, serving people with disabilities, people in poverty, veterans, people struggling with addiction and mental illness, and people facing homelessness. S:US supported housing, like the building I live in, has dedicated staff and support services that help residents overcome challenges. Supported housing offers an opportunity to New Yorkers like me, who need a little extra help, to turn our lives around.

I have had a lot to deal with since the pandemic started. Three of my family members died from COVID-19, my daughter had a miscarriage, and I do not have the best relationship with my kids. It all felt like too much to bear and I began to think there was no reason for me to continue to live. I felt alone and didn't know what to do to make things better. One day I decided it may be better if I wasn't here anymore and I frequently began to think about suicide. I felt sad, scared, angry, and hopeless.

I know that a lot of people have been depressed and thinking about suicide because of the pandemic. A recent survey by

the CDC found that 40% of those surveyed reported an increase in mental health and addiction related challenges, and 1 in 4 young adults reported having contemplated suicide. The survey also found that the toll is falling heaviest on young adults, caregivers, essential workers, and people of color.

Fortunately, I had a lot of people who reached out to me to help. S:US staff have been trained in [safeTALK](#) suicide prevention to help people like me who are having a hard time. They saw the warning signs and knew that talking with me in an open, direct, and honest way would help. They saw that I was overwhelmed, and I told them how I was feeling. My Program Director called me, and other staff checked on me too. My Wellness Coach started to check on me twice a day and let me know they're here to help. They listened to me and showed that they care.

My Wellness Coach also reminded me how much I care about my family and how they would feel if I took my life. That was really helpful—I needed to hear that. My niece calls me multiple times a

week and when other family members heard that I wasn't doing well, they started to call and check in on me too. The more I knew that people cared, the less isolated and alone I felt and the more the thought of taking my life faded.

I now take medication for depression, which is helpful. I meet monthly with my psychiatrist and have telehealth sessions with my therapist. I also try to do things to feel like my old self again. I started exercising (because I love to cook and eat), taking short walks, calling my girlfriend and visiting her on the weekends, watching my favorite TV shows, reading novels, and playing games on my phone. I stopped doing a lot of that stuff when the pandemic began, and I started to lose family members to the virus. Taking naps, listening to music, and eating ice cream helps me too.

I'm doing better now but I still have some bad days. I know that I can reach out to people and I remind myself how far I have come. I also know that there are people I can call and talk to when I am

*see Preventing Suicide on page 26*

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# Using Local Data to Reduce Suicide Death

By Barbara Bernstein, PhD, MPH, Chief Planning Officer, MHA of Westchester, and Michael Orth, MSW, Commissioner, Department of Community Mental Health, Westchester County

**S**uicide is often considered to be the most preventable cause of death. Yet, recent years have seen steadily rising numbers of loss to suicide in the United States. This rise has occurred despite the cultural shift that has allowed the fact of suicide to come “out of the closet”; despite the cultural shift that recognizes that thoughts of suicide are not rare; despite the cultural shift that encourages individuals to talk about these thoughts; despite the cultural shift that encourages individuals to seek the support and assistance that is best for their individual needs and preferences; and despite the cultural shift that recognizes that hospitalization is not necessarily the most helpful intervention. The concept of “deaths of despair” - deaths ultimately due to suicide, drug overdose and alcoholism – but driven by social and economic forces that render life so challenging for so many - has become part of our lexicon. We understand so much about risk factors at the individual and societal level. Our clinical and peer support skills have improved. We are more skilled at identifying and intervening with emerging crises. So why do we continue to lose loved ones at an increasing rate, and most importantly, what can we do to reverse this painful reality?

To address this community problem, Westchester County recently launched a Suicide Fatality Review Team (SFRT). The SFRT is a public health approach that analyzes local data to identify risks specific to Westchester County in order to develop specific county-level prevention and intervention approaches. Westchester is one of four sites selected by the New York State Office of Mental Health to adapt this effective model which was developed in Washington County, Oregon. In Westchester, the Review Team is convened under the auspices of the Westchester Suicide Prevention Task Force. The SFRT is comprised of the Medical Examiner, the writers of this article who Co-Chair the Task Force, and additional representatives of Westchester DCMH, DOH, DSS, first responders, schools, the VA, and community organizations.

The mandate of the Review Team is to, with family consent, review previously collected information about the individual who has died by suicide in order to identify commonalities about the circumstances of these deaths. The Oregon model creates a mechanism to bring together information that previously existed only in silo-ed systems. This information may come from, for example, the Medical Examiner, law enforcement, medical or other systems. The information is reviewed not to assign blame but to identify systems-level interventions that may prevent future similar deaths.

Analyzing aggregated information, our goal in Westchester is to identify specific risk and protective factors to develop targeted prevention and intervention strate-



**Barbara Bernstein, PhD, MPH**

gies. For example, as the Oregon program accumulated information, they identified that on several occasions, household pets were brought to local shelters prior to an individual's death by suicide. This realization led to ‘gatekeeper’ level suicide risk-awareness training for shelter workers and creation of a mechanism to connect people at imminent risk to effective supports and services. Similarly, training of staff at a motel which had been the site of several suicide deaths enabled staff to recognize individuals at imminent risk and to save lives. Thus, they trained the people who were among those who were the last to see the deceased, expanding the traditional training focus from traditional caregivers such as mental health and medical professionals and clergy. Using this model, preliminary data indicate that between 2012 and 2018, Washington County, Oregon reduced the occurrence of suicide death by 40 percent.

A 40% reduction in lives lost stands alone as a herculean accomplishment. When we consider the ripple effects of each individual's death on their family, closest friends and communities, the magnitude of that effect is so much greater. Recent research suggests that for each death by suicide 135 people are affected. <https://suicidology.org/facts-and-statistics/>

Through the Suicide Prevention Task Force, we have established an informal ‘advisory’ group comprised of individuals who have lost a loved one to suicide – our group includes parents, parents-in-law, grandparents, spouses, and siblings. It is their stories, their experiences that bring faces and a 3-dimensionality to the data and to our work. While the work of the SFRT focuses on data and trends, we are driven by the personal, underlying stories and experiences.

The public health approach of identifying problems and trends in order to develop, implement and test prevention and intervention strategies is one component of an effective suicide prevention plan. In addition, work continues at the individual clinical level. For example, services delivered by MHA of Westchester incorporate a continuum of suicide prevention and intervention strategies. Clients complete a



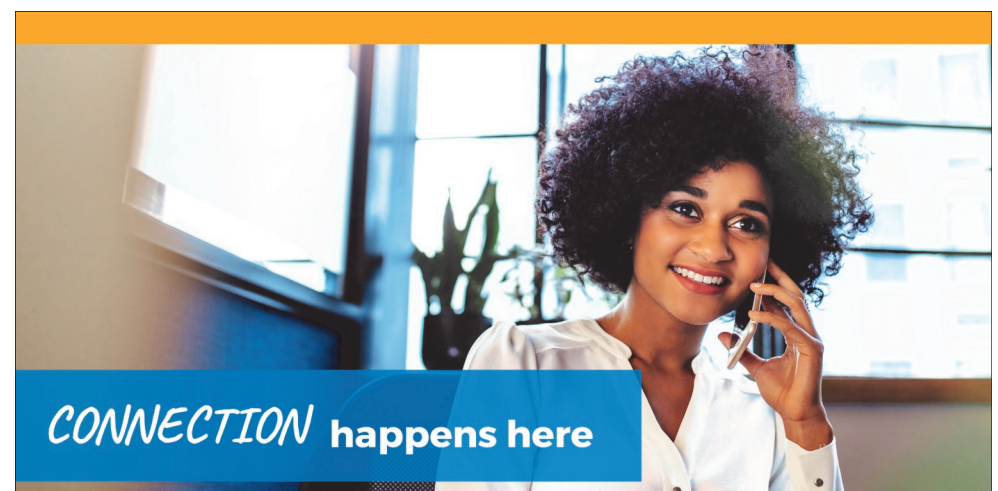
**Michael Orth, MSW**

suicide screening at the time of intake and again whenever indicated, either because of particular clinical content or due to circumstances – such as transition from a hospital stay. When a screening is positive for suicidal thinking or planning, a more complete assessment, which then informs the course of treatment and support, is done. This includes creation of a safety plan which identifies the individual's “triggers” and warning signs, as well as

an individualized toolkit of responses, ranging from drawing on internal resources to informal supports to formal supports and services. Our clinic services utilize a risk stratification approach which helps us identify individuals for whom additional attention is required. Peer support services are an integral part of our work. In collaboration with Westchester DCMH, our Enhanced Peer Services assist with transitions from hospitalizations. Beginning by establishing connection prior to discharge, our peers assist with tangible needs such as transportation, obtaining medication and needed supplies, food, and most importantly, relationship with others. Utilizing their own lived experience of mental health challenges and recovery, our Peer Specialists are particularly helpful at these times.

Staff training is an essential component of our work. Staff who have direct contact with clients complete training in administering the Columbia-Suicide Severity Rating Scale (C-SSRS) screening tool, and the Stanley-Brown Safety Plan, as well as either safeTALK or ASIST training, which is also open to all other staff. Our Peer Support training program, which prepares individuals to complete OMH Certification, includes suicide awareness and intervention training. We continue to incorporate additional

*see Using Local Data on page 31*



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# Does Our Healthcare System Perpetuate an Epidemic?

By Ashley Brody, MPA, CPRP  
Chief Executive Officer  
Search for Change, Inc.

Suicide has been rightly classified as an epidemic, as evidenced by a precipitous increase in its incidence in recent decades. Between 1999 and 2018, the rate of completed suicides has risen by 35% in the United States (Centers for Disease Control and Prevention, 2020). Some authors suggest suicide and associated “deaths of despair” account for recent decreases in life expectancy and the reversal of a longstanding trend that had enabled many Americans to live longer and healthier lives than their forebears (Christensen, 2019). The causes and antecedents of this epidemic are complex, and effective solutions must account for innumerable factors that lead people to end their lives. Timely access to quality behavioral healthcare (or the lack thereof) purportedly plays a prominent role among the array of causes, and a substantial body of research has been built on the presumption expanded access should reduce the incidence of suicide (Rand Corporation, 2018). Other authors have advanced countervailing conclusions, however (Case & Deaton, 2020). They assert the healthcare system (which includes the health insurance, pharmaceutical, medical, and associated industries) plays a particularly insidious role in the perpetuation of deaths of despair among certain populations. Their conclusions suggest our suicide epidemic is largely iatrogenic in nature. That is, the system that should ameliorate it actually exacerbates it.

This provocative proposition follows an extensive analysis of the interrelationship between adverse economic trends and deaths of despair and the manner in which the healthcare system is implicated in the former and, by corollary, the latter. In 2018, healthcare spending in the U.S. constituted 18 percent of its gross domestic product (GDP) (Centers for Medicare & Medicaid Services, 2020). It eclipses spending on defense and education and vastly exceeds the healthcare budgets of other industrialized nations. The U.S. is also unique in its reliance on employer-provided health insurance, the costs of which have increased steeply in recent years. Employers that incur ever-increasing health insurance expenses have fewer resources to commit to employee wages and other forms of compensation. The average cost of employer-sponsored health insurance plans grew by 121 percent between 1999 and 2017, whereas median household income grew by just two percent during the same period (Johnson, 2019). Such wage suppression disproportionately affects low-skilled workers, a cohort especially susceptible to suicide and deaths of despair (Case & Deaton, 2020).



Ashley Brody, MPA, CPRP

In consuming a massive share of national resources, the healthcare system has emerged as a leading culprit in rising income inequality, the effects of which have proven especially deleterious to those at the bottom of the economic ladder. Healthcare expenditures do not merely lead to wage suppression by consuming resources that would otherwise be available to employees. They destroy jobs by inducing employers to eliminate positions through automation, outsourcing, and other measures that relieve them of their financial burden (Case & Deaton, 2020). Low-skilled and “blue collar” positions have stood squarely in the cross hairs of this trend. Those who might have secured well-paying jobs in the manufacturing and service sectors, potential gateways to the middle class that do not require post-secondary education, have witnessed the virtual disappearance of these industries and the loss of their opportunity to claim their share of the American Dream.

It is therefore not surprising that the prevalence of suicide and deaths of despair associated largely with alcohol and drug abuse are considerably greater among individuals with limited education. They are also more prevalent in geographic regions whose industries have been eviscerated by automation, globalization, and other disruptive trends. Simply put, regions in which larger fractions of the working-age population are jobless have higher incidences of suicide and deaths of despair (Gawande, 2020). It is not necessarily an absence of healthcare or behavioral healthcare in particular that leads to such adverse outcomes, but an absence of opportunity. This follows an emerging body of research that suggests healthcare plays a relatively minor role in health outcomes, whereas other factors such as stable housing, reliable income,

adequate nutrition, and educational and vocational opportunities are considerably more instrumental to health and wellbeing (National Academy of Medicine, 2020).

Other industrialized nations have grasped and operationalized these facts, as evidenced by their expenditures in healthcare and social welfare services and the outcomes associated with their investments. Although the U.S. spends considerably more on healthcare than most other industrialized nations, it also spends less on social welfare services (Squires & Anderson, 2015). Social welfare spending constitutes approximately 9% of the U.S. GDP, but it consumes an average of 15% of the GDP of other industrialized nations (Bradley & Taylor, 2013), and these nations outperform the U.S. on several critical measures of population health (Freeman, Kadiyala, Bell, & Martin, 2008). Significantly, these nations also have a lower average incidence of suicide than the U.S. (World Health Organization, 2020). One should not conflate a correlation between health and social welfare

spending and rates of suicidality with causality. Nations that commit a larger share of their resources to social services enjoy other distinctions that surely influence rates of suicide and other indicators of population health. Nevertheless, these data hold broad implications that warrant careful examination.

Prospective solutions to the suicide epidemic must acknowledge the outsized scope of our healthcare system and the deeply embedded inefficiencies and externalities that exacerbate conditions it was designed to correct. This requires immense political will. Effecting structural changes in a system of such depth and breadth would surely rankle deeply entrenched (and deep-pocketed) interests. Yet nothing less than a full accounting of the myriad causes of this crisis and the role our healthcare system plays in perpetuating it will reverse this tragic trend.

Ashley Brody, MPA, CPRP may be reached at (914) 428-5600, Ext. 9228 or at [abrody@searchforchange.org](mailto:abrody@searchforchange.org).



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<sup>1</sup> As reported by the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES).

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# The Importance of Building Community and Family Support with Latina Teens at Risk of Suicide

By Julie Laurence, LMSW,  
Beatriz Coronel, MA, and  
Rosa M. Gil, DSW  
Comunilife, Inc.

Comunilife believes that health disparities affecting the Latinx and other communities of color can be mitigated through an increase of community defined services. Comunilife's Life is Precious™ (LIP) program is the only program specifically designed to serve Latinx adolescents who have experienced thoughts and/or attempts of suicide and suffer from depression. LIP was started in 2008, by Dr. Rosa Gil, Comunilife's Founder, President and CEO, in response to the alarming statistics released by the CDC about the high rates of suicide ideation and attempts among Latina adolescents. According to the CDC's 2020 Youth Risk Behavior Survey (2019 data), more than 18% of Latina teens in NYC seriously considered and almost 10% attempted suicide. New York State statistics show that suicide is the second leading cause of death for Latino teens. LIP was created, with community input, to address this crisis. What began as one LIP center in the Bronx has expanded to four program sites across New York City. In addition to the Bronx, centers are now located in Brooklyn, Queens



Julie Laurence, LMSW

and Manhattan. LIP has reached hundreds of girls and families since its inception.

We know that there are multiple contributing factors that result in young Latinx teens at risk of suicide behaviors. Research findings show that family conflict, poverty, acculturation, stress, trauma, domestic violence, sexual abuse, academic failure, bullying and anti-immigrant sentiment; cou-



Beatriz Coronel, MA

pled with the stigma of mental illness and the lack of culturally competent mental health providers are the major contributing factors (Zayas, Gulbas, Fedoravicius, Cabassa, 2010). LIP's cultural and gender responsive programming addresses these factors with positive youth development activities, trauma-informed case management services, and family engagement.

## LIP Approach

LIP is committed to serving Latinx teens and their families by providing robust programming that reduces risk factors, increases protective factors, and builds a supportive community. The program is equally as committed to reducing the stigma of mental health in Latinx communities by raising awareness through culturally and linguistically relevant workshops, outreach, training, public service announcements, and social media. And by developing strong partnerships with stakeholders at schools, mental health clinics, hospitals, youth serving agencies and grassroots community organizations. Direct support services not only normalize mental health needs but build understanding and healing in safe and creative spaces.

## Who we Serve

Life is Precious™ serves Latina teens, ages 11 to 17, who are immigrants or first generation Latinx. Nearly all live in some of NYC's lowest-income neighborhoods and are living with depression or other diagnosed mental illness. We work with a diverse Latinx population including families from the Dominican Republic, Puerto

*see Latina Teens on page 32*



Comunilife provides vulnerable communities with housing and culturally sensitive supportive services.

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# Care Transitions: A Critical Time to Prevent Suicides

**By Jason Lippman**  
**Founder & Principal**  
**Jason Lippman Solutions, LLC**

**T**he transition from inpatient psychiatric care to outpatient behavioral health treatment is fraught with elevated risk for people with histories of suicidality. According to the National Action Alliance for Suicide Prevention (Action Alliance), suicide rates are 300 times higher for individuals during the first week after leaving inpatient behavioral health care, and 200 times higher in the first month.

Keeping people connected to their care and preventing suicide after discharge, starts with scheduling an outpatient appointment for as soon as possible (within 24 to 72 hours) at a time and place that fits with the person's lifestyle. Sadly, HEDIS data indicates that one-third to one-half of individuals never see an outpatient appointment within the first 7 or 30 days. Similarly, a recent study published in JAMA Network Open found that less than half of youth admitted to a psychiatric hospital (ages 10 to 18) received follow up care within the first week of an inpatient stay.

Suicide is a complicated public health issue requiring many entities across the health and social service systems to work together. Key ingredients to help prevent suicide during the transition from inpatient to outpatient care include:

- Immediate and continuous follow up after a visit to an emergency room or stay in an inpatient facility.
- Ensuring that family members and significant others are made aware of the appropriate steps to support their loved ones (included in appointment reminders, information related to treatment plans and ways to reduce access to lethal means); and
- Forming collaborations between inpatient/emergency departments and outpatient community providers to carry out rapid follow up after discharge.

Two important points to remember is that discharge planning begins after admission (within 24 hours) and that care does not end at discharge. People in transition from inpatient to outpatient care should be a priority, where "inpatient" continues to stay connected and "outpatient" circles back to let them know that they can now stand down.

## Initiate Caring Contacts

One successful intervention called caring contacts involves making a phone call or sending a text or email a message of support within the first 24 to 48 hours after leaving the hospital/inpatient facility. Long ago, Dr. Jerry Motto at the University of California studied caring letters, showing how simple notes were enough to keep individuals connected with their providers and reassure that somebody cares about them and that they matter. An NIH study documented that sending follow up postcards "less expensive and



**Jason Lippman**

more effective than usual care." Greeting cards signed by the treatment staff is another thoughtful way to follow up in addition to more immediate digital means. It is advantageous to use automated features/reminders to assure on time communication of caring contacts. These notes can provide hope for someone navigating the gaps between inpatient and outpatient care and are important to hear along the recovery journey.

According to Dr. Michael Hogan, former NYS Commissioner and an architect of the Zero Suicide movement, "an affirmative message of support can be immensely powerful because suicide is a disease of isolation and loss of hope. There are lots of different approaches that can work, including calls, emails, texts, visits from friends. Even things like utilizing "Alexa" are being researched."

In most insurance arrangements, the time for caring contacts is not billable. The inpatient facility has made the referral and the outpatient provider is overcapacity. However, peer support specialists, case managers and hospital liaisons can be made available to follow up and are beneficial for helping to bridge gaps and jump over pitfalls that appear in between the ending of inpatient care and beginning of the first outpatient appointment. Additionally, clubhouses are a useful means for social support, especially if family members are no longer in the picture for care recipients.

## Cutoff Lethal Means

Research conducted at Harvard University's Injury Control Research Center shows that the suicide rate in the United States is almost twice that of homicide. Gun ownership and the availability of lethal means in the home influences the survivability of a suicide attempts, according to studies. Additionally, a strong link was found between states rife with guns and rates of suicide. In states with more guns, higher amounts of suicides occur and vice versa.

Gun sales have surged during COVID-19 with more guns in the homes of people sheltering in place, according to Every

Town USA. Likewise, a recent study by the CDC shows that one in four young adults (18 to 24) had suicidal thoughts in the last 30 days, as well as over 30% of unpaid caregivers and 22% of essential workers. What will this mean for people in despair and/or under increased stress, particularly for young men with easy access to guns?

## Create Seamless Care Collaborations

Over twenty years ago (in 1999), the U.S. Surgeon General issued its Call to Action to Prevent Suicide as a catalyst to the National Strategy for Suicide Prevention (NSSP). In conjunction with greater efforts dedicated to suicide prevention, the rate of suicide in the United States has steadily increased between 1999 and 2018 (by 35%), according to data collected by the CDC. With suicide rates increasing over the last 20+ years, the Action Alliance more recently worked to update the National Strategy. One takeaway is to target our efforts at areas with the greatest likelihood of reducing suicide.

Linda Rosenberg, Executive Director of External Relations at Columbia Psychiatry suggests that, "there are basic changes we can make to reduce death by suicide including increased payment rates for collaborative care (screening for mental and addictive disorders, on demand virtual psychiatric consultation and trained care managers) with required

adoption by primary care practices."

Employers, health insurers and health care providers should zero in on increasing access to affordable and effective in-network specialty behavioral providers to better enable the detection of behavioral issues and tracking of clinical outcomes early on, as detailed in a report by The Path Forward. The report recommends supporting primary care settings to address both the behavioral and physical problems collaboratively, ensuring compliance with parity laws and locking in the availability of tele-behavioral health services implemented during COVID-19.

Rosenberg also stresses the need for "communities understanding and using data (what group(s) have the highest rates of death by suicide) and focusing interventions on the highest risk groups not what's currently trending; and neighborhoods/communities creating virtual safety nets of providers – hospitals, community clinics - that commit to no wrong door and implement seamless, personalized referrals among the safety net."

Right now, accountability gets blurred by a fragmented system of inpatient and outpatient providers, care coordinators, health plans, etc. These entities are useful for coordinating care and linking to specialty behavioral health services, but consumers can get lost in the system, losing access to vital supports. Additionally,

*see Care Transitions on page 30*



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# Zero Suicide in the United States

By Rachel W. Bush, PhD  
Assistant Professor of Psychiatry and Behavioral Sciences, New York Medical College, and John I. Gerson, PhD,  
Licensed Clinical Psychologist  
Private Practice- Katonah, NY

We have started to finally recognize and respond to the serious public health concerns about suicide in the United States. The “Zero Suicide” ZS initiative was developed to provide a systemic approach to the prevention of suicide (Laboullere, et al., 2018). In 2010 the National Action Alliance for Suicide Prevention (NAASP) created the aspirational goal of “Zero Suicides” with a primary focus on prevention. We came to recognize the importance of bridging the gap between science and routine clinical practice. The field developed standardized metrics (Posner, et al., 2011) in response to suicide as a tremendous public health issue. We finally are utilizing evidence-based suicide prevention practices to improve clinical care (Brodsky, et al., 2018). This impressive 10 year review of suicide prevention research is now informing the ways in which mental health professionals approach and treat patients.

ZS is based on a model of challenging our false assumptions about our behav-



**Rachel W. Bush, PhD**

ioral health system’s neglect of suicidal patients. The fundamental organizing principle of ZS is that suicide is preventable. The science of improving suicide risk assessment speaks for itself. This is quite different from Coleridge (1817), who is best known for ushering in the Romantic age of poetry in England and calling for “That willing suspension of disbelief for the moment, which constitutes poetic faith.” ZS is not about making fantastical events believable, Implementing ZS in “real-world” clinical settings continues to inform the field on how to



**John I. Gerson, PhD**

use empirically supported care for preventing suicide in outpatient behavioral health systems. Worldwide suicidality experts (U.S. DHHS, 2012) have confirmed the need for prevention.

The World Health Organization has reported that more than 800,000 people die by suicide annually (WHO, 2017). The Center for Disease Control and Prevention reported that in 2016 alone, nearly 45,000 Americans died by suicide. Suicide rates are 22% higher in the United States than global averages (CDCP, 2017). The Zero suicide website (SPRC, 2017) states that

the public health crisis is occurring now, because the American healthcare system is fragmented. Millions of people continue to struggle to access affordable healthcare (American College of Emergency Physicians, 2017).

The national strategy for suicide prevention has identified three key reasons why we have experienced significant treatment failure: 1) detection of suicide risk is inadequate; 2) evidence-based suicide specific interventions are not deployed; and 3) intensity of care is not increased during high risk periods (U.S. DHHS, 2012). We have found that 20-80% of those that suicided in the US have accessed clinical care in the year prior to death (Ahmedani et al., 2014). In addition, nearly 50% of those that suicided had accessed care within 30 days of dying (Ilgen, et al., 2012)

Although preliminary, it is exciting that 25 studies have had over than 70% reductions in suicide in the year after utilizing ZS interventions (Hampton, 2010; Centerstone, 2016). ZS offers seven elements to implement effective suicide care. The three implementation elements include LEAD (create organizational culture change about suicide prevention). With outstanding leadership the safety focused team defines suicide prevention

*see Zero Suicide on page 28*



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# Empowering Adults to Recognize and Respond to Youth in Suicidal Distress

**By Ali Rainone, LMSW**  
**Social Worker, Westchester Jewish**  
**Community Services (WJCS)**

**T**he statistics regarding youth mental health are not only strikingly frightening but they point to the inexcusable reality that what is currently being done to address the problem is not working. According to the National Alliance for Mental Illness (NAMI), one in five teens and young adults live with a mental health disorder. Of youth with major depression, 64.1% do not receive any mental health treatment. Additionally, in 2018, the Center for Disease Control (CDC) reported that suicide is the second leading cause of death for individuals age 10-34.

When it comes to addressing mental health and suicide, youth come with their own unique challenges. Their physical, mental, emotional, and social development have a direct impact on their mental health and can lead to suicidal ideations, attempts, and completions, substance use, self-harm, and other maladaptive coping skills. Due to their particular set of developmental needs, this demographic may struggle to respond to treatment modalities primarily designed for adults. Therefore, it is vital that the adults in a youth's life be able to respond to signs of suicide risk and emotional crisis in an effective way. Fortunately, many evidenced-based treatments have been adapted and modified to specifically target their needs. Those changes, combined with the introduction of training programs such as the evidence-based and nationally recognized certification course Youth Mental Health First Aid (YMHFA), enable youth to get the help they deserve earlier and, thereby, have a more successful outcome.

Westchester Jewish Community Services (WJCS), the largest provider of outpatient community-based mental health services in Westchester county, offers YMHFA trainings to teachers, first responders, health and human services workers, parents, coaches, camp staff, and individuals working in other youth-facing organizations. Recognizing the need for increased awareness of risk factors and warning signs, the training teaches adults to identify, understand, and respond to various mental health challenges and crises, highlighting suicide. The 6-hour course provides basic knowledge of mental health diagnoses and challenges as well as a 5-step action plan used in a variety of crisis and non-crisis situations. Participants learn the skills needed to reach out and provide initial help and support to a youth who is struggling. This first aid is given until appropriate treatment is received or until the crisis resolves.

YMHFA recognizes that adults often feel scared, sad, helpless, and confused about what to do and say when an adolescent or young adult has a mental health crisis. It is bewildering to see a young person, with seemingly endless opportunities and life ahead, struggle with overwhelming emotions and hurt. It is even more difficult to comprehend that think-



**Ali Rainone, LMSW**

ing about suicide can be seen as a comforting escape to a youth because he or she views it as a way out of pain. However, despite this uncertainty, the adult must respond to each situation thoughtfully and empathetically.

It is crucial that adults approach a young person who expresses suicidal thoughts and feelings in a way that is validating, caring, and helpful. At a time when a youth feels most vulnerable, every step taken needs to make him or her feel safe and seen, not judged or misunderstood. Some adults freeze in these situations because they do not have the knowledge, skills, or resources to strategically move forward.

In YMHFA trainings, adults learn to give up misconceptions, such as thinking that talking about suicide to a struggling teen will plant the idea in their head or assuming that a youth is talking about suicide just to gain attention and therefore should be ignored. Without a doubt, a young person explicitly voicing suicidal thoughts and feelings is seeking attention – and rightfully so. Those who verbalize suicidal thoughts or intentions are allowing their deepest internal screaming to be heard in the outside world. As adults, we must be ready to help them.

YMHFA emphasizes that all suicidal statements must be taken seriously. Acknowledging someone's pain and mastering the art of sitting in that heavy space with them is extremely powerful. Lending your unconditional head, heart, and ear to open the lines of communication can contribute to shattering the stigma and taboo that is keeping the one who is suffering feeling alone or hopeless.

The balance between needing to take action but not overreacting can be hard to strike. Similarly, there is also a fine line between remaining calm but not under reacting. A reaction that leans towards either extreme can leave the youth feeling fear, shame, guilt, or regret. The importance of being genuine, curious, and non-judgmental cannot be overstated. Asking open-ended questions and giving the young person an opportunity to tell his or her story is a valuable tool to establish

trust and clarify feelings. It is also useful to explore core thoughts and feelings that are often disguised as anger, frustration, defiance, or irritability. The conversation will not emulate a therapy session or take the place of professional treatment, but rather offer a listening ear and beginning step toward finding wellness.

As a youth shares suicidal thoughts and feelings, it can be tempting to highlight the good in their life, making statements about their high grades, large friend group, or athletic and artistic talent. While these may be true, bringing them up to combat suicidal thoughts or feelings will only discredit their pain. We must also be vigilant to not undermine their pain. Making threats, trying to evoke guilt, or making accusations of being histrionic--saying things like "If you say that again I'm calling 911" or "Do you know what this would do to your family?" or "Stop being dramatic, it was just a breakup" are absolute conversation enders.

When asking the pressing question about intent, the best practice is to be direct, confident, and reassuring. Consider your relationship with the youth and the most natural way for you to ask if they are thinking of suicide. If it feels uncomfortable to go straight to the point, preface the question with details about what is going on in the young person's life and how they are feeling. For example, "I know

that you're going through a breakup right now and feel really sad and alone. Are you having thoughts of hurting yourself?" Be collaborative and include the youth in the problem-solving process, even if what ultimately has to be done is something they do not want, such as getting their caregivers or professionals involved. Above all, thank them for being brave and honest enough to share their story and let you in.

Since 2013, WJCS has been the driving force in the Mental Health First Aid initiative, having trained nearly 2,000 participants throughout Westchester in both Youth and Adult courses. There are now virtual and blended learning versions of Youth Mental Health First Aid in order to reach a larger audience and the updated curriculum includes such topical issues as social media, bullying, and trauma. One of WJCS's strongest partners in the Mental Health First Aid initiative is the Westchester County Department of Community Mental Health.

"The mental health of all Westchester County youth is a top priority," said Michael Orth, Commissioner of the Westchester County Department of Community Mental Health. "YMHFA training is a great tool that provides adults with concrete skills in identifying and

*See Empowering on page 26*



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# Suicide Prevention on Campus: Perspectives from a University Student and Professor

By Catherine Choi and  
Brett R. Harris, DrPH

**S**uicide is the second leading cause of death among college students. According to a 2017 American College Health Association survey, over half of college students feel hopeless, almost two-thirds overwhelming anxiety, and over one in ten have seriously considered suicide. Among those who receive mental health services, over one-third have seriously considered suicide and one in ten have attempted suicide (Center for Collegiate Mental Health, 2018). In response, university administrators and health directors across the country are increasingly breaking their silence and taking action to address mental health and prevent suicide on their campuses. This article presents the perspectives of a Cornell student and a Cornell alumna and Clinical Assistant Professor at the University at Albany School of Public Health.

*Perspective from Catherine Choi, Senior, Cornell University:* At Cornell University where I attend as an undergraduate, the campus health center announced a plan to increase flexibility for the Counseling and Psychological Services (CAPS) program this past year, thereby increasing its accessibility for all students. This demonstrates,



**Brett R. Harris, DrPH**

at the very least, that administrators are listening to students' growing demands. Cornell also offers in-person and telephonic peer counseling via its Empathy, Assistance, and Referral Service (EARS). Yet mental wellness is regularly treated as merely an afterthought, and data suggests the same for other schools. This comes as

no surprise to the student body. We all undergo both the good and the ugly of the hyper-productive, pre-professional, and sometimes lonely student experience. The troubling symptoms that result are neglected, justified by a pervading mindset that mental health can wait in line; there are other more pressing matters that take precedence.

In addition to campuses simply acknowledging the importance of mental health, there must be supports for students – as well as faculty and staff – to seek help. While it is a substantial step in the right direction to normalize conversations about mental health, normalizing prevention, intervention, and treatment to achieve the ultimate goal of mental wellness is an entirely separate and equally convoluted process.

One barrier to help-seeking is personified in my classmate, Kristi Lim. A fellow student at Cornell, she writes that “no external figure should strip from an individual the autonomy to make the final call,” and described a suicide intervention training program as an “illusion” for “anything more than a facilitatory step in a longer, idiosyncratic process” in an opinion piece she titled: Why I’m Choosing Not to Seek Professional Mental Health Care. Despite sparking immediate backlash, Lim’s article suggests that some

students undermine medical treatment and participating in evidence-based training, willingly opting for an independent path to mental wellness instead.

Another barrier is a more recent phenomenon, wherein de-stigmatization on a college campus adopts desensitization as well. In this case, discussing mental health and illness is normalized but unproductive. Desensitization normalizes mental illness itself. This can manifest in both apathy and a “struggle Olympics”-type campus culture where students compete as to who has it worse or whose struggles are more substantial. The following are some ways to normalize and promote mental wellness and prevent suicide on college campuses:

Start Talking about Mental Health and Provide Access to Services and Resources. In both the administrative and student spheres, colleges should continue their work in streamlining mental health initiatives. Within different campus organizations, students can put mental health on their agenda and provide information and resources for seeking help. Faculty should add information about mental health resources on their syllabi and provide accommodations for mental health reasons. Administrators,

*see Campus on page 31*

## Know the Signs: Help Prevent a Loved One's Suicide

By Wendy Martinez Farmer, LPC  
Crisis Solutions Lead  
Beacon Health Options

**T**he following is a true story by a Beacon Health Options employee. Anna was one of the most talented and creative people I had ever known, and just about everyone who met her felt the same. She was a perfectionist to a fault, and there was seemingly nothing that she did not do well. The one person who did not see this though was Anna herself. As I got to know Anna, she shared more and more about her struggle with depression from the time that she was a small child as well as her persistent feelings of not being good enough and not really fitting in. Eventually she had to be hospitalized and underwent electroconvulsive therapy. It was after this treatment that her symptoms finally began to improve, and this improvement would follow her through her final weeks. She was able to do things, without it seeming like such an effort, that she had not felt like doing in a long time. She went camping with friends, started planning a vacation for the upcoming summer with her family, and began talking about pursuing her doctoral degree. Sadly, these plans would never come to be. The details about her final day are not known to me, as I was not with her. Many people were truly shocked because they

had not been aware that Anna was struggling with anything.

Unfortunately, the story of Anna is not unique or unfamiliar to many people. Often, the friends and families of people at risk for suicide have no idea of that risk. It's only when there is death by suicide that people learn of the lifelong pain and anguish their loved ones suffered. Sadly, many loss survivors are left with lingering questions and often, crippling guilt.

How did I not know? How could I not have seen it? Why didn't I do anything?

While behavioral health professionals have shared with family, friends, neighbors and co-workers that everyone can play a role in suicide prevention, we have fallen short when it comes to teaching practical ways to identify those at risk and how intervene which has left survivors feeling shame.

Recognizing September as National Suicide Prevention Awareness Month, Beacon wants to shed light on the warning signs and provide tips on what you can do to help.

### Warning Signs for Suicide

Individuals at risk for suicide may not communicate about their thoughts or intentions directly, but the following situations indicate your loved one may be at risk:

- A person thinking about suicide may talk about having no reason to live. Depression – the number one cause of suicide – is often related to a sense of loss and hopelessness. Listen to the person to see how they talk about dealing with detrimental events piling up.

- A person may appear to be preparing for some kind of end or departure from routine. For example, a friend calls late at night to apologize for a rift that occurred years ago. A co-worker trains a colleague to do his job. Be on the alert if someone you know starts tying up loose ends.

- Your loved one might talk or joke about different methods to die by suicide or you may find out they are researching suicide. Take all talk of suicide seriously. Pay attention. Is this person dealing with many difficulties?

### How You Can Respond

*Ask the question:* If you are concerned that your loved one may be thinking of suicide, the most important thing you can do is ask the question. It is not easy, but most of the time individuals in such great pain are relieved that another person is willing to talk about such a difficult subject. There is no evidence that talking about suicide will cause suicide. It often prevents it. A good way to start is by saying something like “I have noticed you

have had a lot of very stressful events in your life lately. Sometimes people in your situation think of suicide. Are you thinking of suicide?”

*Listen to keep them safe:* Be prepared to listen to their story. Talk to your loved one in a warm, nonjudgmental way. Say you care and want to help and give assurance you will follow through with your support. Make sure you ask them if they have already done something to harm themselves or have made a specific plan. If they have already set a plan in motion, seek the support of emergency services (911).

*Seek help:* Remind the person they are not alone and reaching out shows courage. Many people have reached the same point in their lives but have managed to find their way back to a meaningful life. You and others are there to help and treatment for behavioral health is available and can be effective.

Most of us are not mental health professionals, but that doesn't mean we can't help a loved one who may be thinking of suicide. The most important thing you can do is to help your loved one get the care they need.

*If you or your loved one is in a crisis and need help immediately, call the National Suicide Prevention Lifeline available 24/7 at 1-800-273-TALK (8255) or text MHA to 741741. These services are confidential, free and available to all.*

# Preventing Suicide Among Suicide Attempt Survivors Using an Innovative Support Group Intervention

By Sae Lee, PhD and  
Patricia Speelman, MA, LMFT  
Didi Hirsch Mental Health Services

Despite ongoing prevention efforts, suicide remains a public health crisis, with reports showing an alarming increase in suicide rates over the past decade in the United States (Hedegaard, Curtin, Warner, 2018). From 1999 to 2017, the age-adjusted suicide rate increased by 33%. In 2018, suicide was the tenth leading cause of death in the United States, accounting for over 48,000 deaths (Center for Disease Control, 2018). Furthermore, there were over 1.2 million suicide attempts in the U.S. (American Association of Suicidology, 2018). Tragically, research shows that less than one-third of people in the U.S. who die by suicide each year receive intervention by a mental health provider in the year prior to their death (Luoma, Martin, & Pearson, 2002). Efforts to change these trends in suicides have become an increasing priority in recent years, with development of interventions that seeks to prevent suicide among those at greatest risk.

One group consistently at extremely high risk are suicide attempt survivors, who are at high risk for not just future suicide attempts but also death by suicide

(Franklin, et al, 2016). Suicide attempt survivors die by suicide at a higher rate (Knesper, American Association of Suicidology, & Suicide Prevention Resource Center, 2010), with one study finding that within the first 5 years of making an attempt that requires hospitalization, 37% made another attempt and 7% died by suicide (Beautais, 2004). Given the elevated risk of suicides among survivors, it is especially important to provide targeted and effective interventions for this group. However, there are only a limited number of interventions specifically targeting attempt survivors that are proven to be effective and not many that use a group format. A group format has the advantage of bringing individuals with shared experiences together in a cost-effective manner to work together to process their experiences, reinforce coping strategies, and reduce stigma associated with having attempted suicide. Many suicide survivors find it difficult to talk about their attempts and their struggles with suicidal thoughts and desires, even among friends and family members who may want to help the most. There is still much stigma and fear and survivors are worried that speaking openly about suicidal thoughts or recent attempts might lead to being hospitalized against their will.

In the 1960s, Norman Farberow, widely considered one of the fathers of

modern suicidology and one of the co-founders of the Los Angeles Suicide Prevention Center, formed a group to give survivors a place to discuss their experiences. His project also provided researchers with an opportunity to learn more about the nature of suicide itself. However, concerns about suicide contagion and fears that a group comprised of survivors of suicide attempts may have iatrogenic effects by actually increasing thoughts of suicide and, thereby, leading to future suicide attempts made Dr. Farberow's plan a controversial one. Because of these challenges, the support group for attempt survivors was not sustained. However, decades later, recognizing the need for an effective and innovative intervention to help individuals at risk for suicide, Didi Hirsch Mental Health Services' Suicide Prevention Center (SPC) developed and piloted its first support group for survivors of suicide attempts (SOSA) in 2011. After the success of the pilot group and positive feedback from group participants, SPC continued to expand the number of groups offered and a few years later developed a corresponding facilitator training for mental health professionals and peers interested in implementing SOSA in their communities. The group curriculum, Manual for Support Groups for Suicide Attempt Survivors, was accepted into the Suicide Prevention Re-

source Center's Best Practices Registry in 2014 and is listed on their website under Resources and Programs ([www.sprc.org/resources-programs/manual-support-groups-suicide-attempt-survivors](http://www.sprc.org/resources-programs/manual-support-groups-suicide-attempt-survivors)). There has been a high level of interest in the curriculum and the facilitator training both nationally and internationally. As of 2020, the manual was disseminated to 1896 individuals in the US and 35 different countries. SPC provided 18 trainings to professionals interested in implementing SOSA in their communities. Through these trainings, SPC trained 219 individuals from 23 states in the US and Australia.

SOSA is an innovative 8-week support group for suicide attempt survivors that offers a safe, non-judgmental place for people to talk about their attempt(s) and its impact on their lives. The group typically has six to eight adult participants (18 years or older) who have made one or more suicide attempts and is led by two facilitators, a licensed clinician and a peer facilitator with lived experience of a suicide attempt. Participants are required to complete an intake interview with a facilitator prior to attending the group. The group is closed to additional participants once an eight-week cycle begins. The support group offers a unique opportunity for suicide attempt survivors to connect

see Support Group on page 33



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# Suicide and NSSI in LGBTQ Youth

**By Thomas R. Grinley, Director, Office of Consumer and Family Affairs, Bureau of Mental Health Services, Division for Behavioral Health, NH Department of Health and Human Services**

**T**he suicide rates for youth, especially between the ages of 15 and 19, have increased dramatically. Suicide is now the second leading cause of death for the ages 10 to 24. It is believed that this reflects a higher level of psychological distress in today's youth. The suicide rates are even higher for marginalized youth such as black and LGBTQ (lesbian, gay, bisexual, transgender and/or queer) teens. LGBTQ youth have a two to seven times greater risk of suicide than cisgender/heterosexual youth.

As much as 24% of suicide attempts may be LGBTQ youth. We know this is greater than the 11.8% rate per 100,000 that we see in youth in general but we are not able to calculate an exact rate because we do not know the total population of LGBTQ youth. Additionally, there is an increased rate of non-suicidal self-injury (NSSI) among LGBTQ youth. We also know there is a greater risk of suicide when youth engage in NSSI.

What is driving these rates? We know that some of the risk factors for suicide and NSSI include a perception of not belonging. LGBTQ youth report twice as

much bullying on school grounds than their peers and see a great deal of cyberbullying. Both are known risk factors for suicide. Eighty percent of lesbian, gay and bisexual youth and 60% of transgender youth report being harassed. Their families and/or peer groups might not accept their choices and lifestyles. Family rejection increases the likelihood of a suicide attempt by eight times. Minority stress theory highlights the impact of discrimination and prejudice and hypervigilance due to the expectation of prejudice and discrimination. It is also common to see internalized prejudice. All of these factors can increase the risk of suicide.

Anti-LGBTQ attitudes in our society can become internalized which is also another risk factor for suicide. The simple act of "coming out" can increase the allostatic load on youth and increase risk factors. Girls have less coming out stress than boys but are more likely to experience depression and suicidal ideation. Attitudes toward gay men is more hostile than attitudes toward lesbian women and boys are more likely to experience physical aggression. Those identifying as bisexual may experience greater prejudice even within the LGBTQ population as it may be seen as a "cop out" rather than a true identity. Transgender youth also experience a great deal of societal rejection and are more likely to experience depression and anxiety. With wide-spread ac-

ceptance of same sex marriage and more tolerant attitudes toward the LGBTQ population, we have, in fact, seen a decrease in suicide rates.

The likelihood of a suicide attempt is highest when these risk factors are present or escalating and protective factors and health coping skills are diminished.

Identifying as a sexual minority may go beyond just acceptance and we may see bullying and even physical aggression. 75% of LGBTQ youth report verbal harassment and one in seven reports physical attacks. As we have already said, youth in general are at an increasing risk of suicide. Throw identifying as LGBTQ into the mix and we see an even greater risk.

Protective factors from suicide include good parental relationships. Another protective factor is feeling connected at school and belonging to a supportive group of peers. Access to LGBTQ inclusive medical and mental health care that can address the unique needs of this population is also a protective factor. For LGBTQ youth, all of these protective factors might be missing.

Within the LGBTQ population, we still see differences based on how individuals identify. Those identifying as bisexual and/or transgender are at even greater risk. Of those identifying as transgender, 30% to 40% have reported suicide attempts.

As stated above, we have actually seen a decrease in suicide in the LGBTQ popu-

lation as the tolerance for these lifestyles has improved. However, we have not seen a decrease in NSSI. LGBTQ youth are three times more likely to engage in NSSI. In a Youth Risk Behavior survey, 67% of reported NSSI was by students identifying as LGBTQ. Same sex attraction before identifying as LGBTQ can increase the risk of NSSI. When asked to explain their NSSI, young people often say it is a coping mechanism that helps to relieve unbearable emotions and reduce internal tension. The majority of LGBTQ youth report that NSSI is due to feeling empty or numb. When asked to identify triggers youth responded that they included distressing emotions, a sense of isolation, relationship difficulties, or school/work difficulties. Minority stress, mentioned above as a risk factor for suicide is also a risk factor for NSSI.

NSSI is seen as a risk factor for suicide attempts but less than 50% of students reporting past NSSI reported accompanying suicidal ideation. In fact, NSSI as a coping strategy may be a protective factor against suicide. Again, within the LGBTQ population we see difference in subcohorts. Bisexual women and transgender men are at the greatest risk of NSSI.

So how can we help LGBTQ youth? Perhaps the most important is to increase family and school support. We know that

*see LGBTQ on page 34*

## Circle of Grief from page 1

sympathy that people received carried mixed messages: no one in my family ever died this way, so I'm really, really, really sorry about your loss. You're probably going to need a therapist to help you get through this death, friends counseled. Overtly and through innuendo, people had reminded these poor souls of the impropriety of their loved one's death. Shame echoed around the room. Shame and anger.

Listening, I realized I felt differently. Somehow, I'd survived my son's suicide with only the pain of his loss and the pain of his pain. For whatever reason, I felt impervious to the implication that I should be embarrassed. Perhaps it was the years of our son's adolescent anorexia that taught me how useless other people's understandings -- or misunderstandings -- of a person's sufferings could be. Perhaps I'd been so preoccupied by fear of my son's death through anorexia that I'd lost track of other people's opinions. It seemed I had reflexively discounted the stigma proffered by the outside world. Somehow, beyond my own consciousness, I'd learned that other people's condemnation was best ignored: it wasn't helpful, it wasn't relevant.

When it was my time to speak, I recounted my husband's and my interview with the priest who conducted our son's memorial service. Ostensibly sympathetic, he opened our discussion with the information that until a few decades ago, priests of his church (Episcopalian) were not allowed to hold a service for a suicide victim. Why had he mentioned this? If he was willing to do the service, did he need

to tell us of the recent -- current? -- unacceptability of our son's means of death?

I told the story to the group but told them that the priest's implied reproach hadn't stuck. I'd forgotten it until tonight, when the people in this room told their stories of shaming. As I talked, I felt my message develop: please don't let people get to you! Don't let them shame you. I felt compelled to explain to the people in the room that the insult of stigma was an additional, unnecessary source of pain.

Stigma, to be honest, is just one of the extra layers of pain for those who've lost someone to suicide. In addition to the stigma of shame, there's the agonizing uncertainty about whether the one you loved knew, really trusted, your love. And there's the horrific knowledge that the person you loved suffered a depth of pain that most of us can only imagine. Every loss is painful, and complicated, but the loss of someone by suicide carries more weight in those extra layers of pain.

But stigma is something you can do something about. At the meeting, many people murmured approval of my combative stance toward stigma, perhaps having gained some relief from a fresh perspective. Their comments reinforced my conviction that we need to speak openly about suicide. By hiding it, you're supporting the notion of its unacceptability. It's important for people to know about suicide so they can learn how it comes about, uniquely for each person. You can't learn about something you're running away from. Let people know. Let them learn. Stigma is something you can do something about.

At the end of the meeting, I left, my face still wet with tears, but with a mission.

## Preventing Suicide from page 17

not feeling well. The Program Director gave me additional phone numbers in case I don't want to talk to anyone at my residence or my family: The National Suicide Prevention Lifeline (1-800-273-8255) and NYC Well (1-888-NYC-WELL or text

## Empowering from page 23

deescalating crisis situations, as well as developing and implementing appropriate action plans, thus improving the safety of our youth."

Overall, our youth are exceptionally resilient and have the maturity and ability to voice and express their pain, despite all the hardships they may face. Unlike many adults, they are often less afraid to be vulnerable and ask for help. Therefore,

## PROS from page 16

getting more support from PROS because being able to call in to groups removes the stress of having to leave my house making it easier for me to attend groups."

Our psychiatric providers, a psychiatrist and a nurse practitioner, are doing all sessions via telehealth. Telehealth adds a new dimension to flexibility which has increased the show rate while ensuring that participants receive the psychiatric support that they need. Our nurse continues to be on-site every Tuesday. Following proper protocols, we are able to ensure that labs are completed, and that medication management and distribution takes place. For participants who are at a higher risk of

"WELL" to 65173). I keep them on my refrigerator door, so I don't lose them.

All in all, I'm doing better and know that I have a lot of people in my corner. I know that healing, hope, and recovery are happening every day. Suicide can be prevented. I'm thankful that S:US has helped me put my life back together.

the adults in their lives must be educated, trained, and supported so they are prepared to respond effectively for when youth do reach out. If not handled properly, it may be the last time that young person will.

*Ali Rainone, LMSW is a social worker at Westchester Jewish Community Services (WJCS) in the Yonkers School-based Clinics and the Mental Health First Aid Coordinator.*

contracting COVID, the nurse makes house calls. No participant has missed an injectable medication or treatment.

We've been encouraging participants to use their natural supports to help increase success of treatment.

We have enrolled two new participants and have re-engaged nine others. We look forward to continuing to enroll new participants.

*Alicia Lore-Grachan, LCSW, is Deputy Executive Director for Rehabilitative Services; and Alice Sorensen, LCAT, MT-BC, is Assistant Director, of PROS, at The Guidance Center of Westchester. Visit us to learn more at: [www.TheGuidanceCenter.org](http://www.TheGuidanceCenter.org).*

# The Impacts of Problem Gambling

**Colleen Jones**  
**Program Manager,**  
**Mid-Hudson Problem Gambling**  
**Resource Center**

According to the CDC (CDC, 2020) suicide is the 10<sup>th</sup> leading cause of death in the United States. This is a concerning statistic and many people struggle with their mental health every day. There are many factors that may lead someone to think that suicide is the only option, but have you ever thought about problem gambling as a source of emotional distress for someone?

There are many people who struggle with problem gambling in the United States. It is estimated that 2 million adults in the U.S. meet the criteria for gambling disorder, with another 4-6 million people in the U.S. struggling with problem gambling (National Council on Problem Gambling, 2020).

For many people, they can gamble and not have a problem. However, for some, gambling can cause problems in their lives. Problem gambling is anytime gambling causes problems or negative consequences in someone's life. Gambling disorder is a diagnosis by a qualified, trained professional determined by the criteria set forth in the DSM5.

1. According to the DSM5, a diagnosis of



**Colleen Jones**

gambling disorder requires at least four of the following during the past year:

2. Need to gamble with increasing amount of money to achieve the desired excitement
3. Restless or irritable when trying to cut down or stop gambling
4. Repeated unsuccessful efforts to control, cut back on or stop gambling
5. Frequent thoughts about gambling (such as reliving past gambling experiences,

planning the next gambling venture, thinking of ways to get money to gamble)

6. Often gambling when feeling distressed

7. After losing money gambling, often returning to get even (referred to as "chasing" one's losses)

8. Lying to conceal gambling activity

9. Jeopardizing or losing a significant relationship, job or educational/career opportunity because of gambling

10. Relying on others to help with money problems caused by gambling

It is important to remember that while all those with a gambling disorder are experiencing problem gambling, not all those struggling with problem gambling have a diagnosable gambling disorder. Whether someone is struggling with problem gambling or gambling disorder, they are at risk of having the negative consequences from gambling seep out into their everyday lives. These effects may not only impact the person struggling with gambling, but also impact their loved ones.

People who struggle with problem gambling are also at a higher risk for struggling with other mental health disorders. Two out of three gamblers reported that their mental health suffered as a result of their gambling problems. In addition to

struggling with gambling, they may be struggling with other mental health problems such as a mood disorders like depression, personality disorder, and anxiety. Someone struggling with their gambling may be cashing in retirement funds, college funds, or taking out additional credit cards and loans. These impacts can cause someone to feel hopeless, desperate, and alone.

These negative effects can take a toll on one's mental health. Sadly, problem gambling has the highest suicide rate among all addictions. When we look at suicide in the United States, 3.9% of the adult population have suicidal ideations and 0.6% attempt suicide each year (CDC, 2015). While this statistic is alarming, we find that for problem gamblers, the concern continues to grow. It has been found that 37% of those struggling with problem gambling and 49% of those with a pathological Gambling Disorder have suicidal ideations. Statistics also show that 17% of problem gamblers and 18% of those with a Gambling Disorder attempt suicide. This rate is much higher than the general population, and we believe it's important to raise awareness of this issue through educating community providers and clients.

Problem gambling is often referred to as "the hidden addiction" because there are no physical warning signs to "test for"

*see Problem Gambling on page 30*

# Strengthening Protective Factors to Prevent Bullying and Suicide on Staten Island

**By Steven Chan, MPH,**  
**Maralie Deprivil, MPH,**  
**Jazmin Rivera, MPH,**  
**Adrienne Abbate, MPA,**  
**The Staten Island Partnership for**  
**Community Wellness**

In recent years, Staten Island (SI) has taken up the nationwide call to action to address suicidal behaviors among youth. During a May 2018 roundtable discussion on mental health issues facing youth, hosted by local elected officials and attended by a multisectoral group of professionals from schools, mental health providers, community-based organizations, and city agencies, anecdotes from clinicians at pediatric behavioral health outpatient clinics raised concerns about the increasing acuity of suicidal behaviors among children as young as 7 years old. Although these instances among young patients were considerably rare, clinicians cited the extent to which some patients went, sharing that some patients reported tying objects around their necks like a noose or testing if certain curtain rods were strong enough to support their weight. Clinicians connected these behaviors with increasing numbers of kids at younger ages talking about feelings of vulnerability, anxiety, and lack of control. Bullying was also prominently discussed at the roundtable,

with stories about how a rise in bullying, especially electronic bullying, has contributed to similar feelings of vulnerability, anxiety, and lack of control. This connection between bullying and suicide has been well documented, but this roundtable highlighted the urgent need for our community to delve deeper at the local level to better understand how bullying and suicide affect SI youth, and assess our community's capacity to meet these challenges.

Following the roundtable, the Staten Island Partnership for Community Wellness (SIPCW), which serves as the backbone organization for TYSA, a collective impact initiative focused on addressing the behavioral health needs of SI youth, took the lead in conducting an assessment. SIPCW completed eight key informant interviews (KIIs) with adolescent mental health service providers on SI, including staff from school-based health centers (SBHC) and outpatient behavioral health clinics. Interviewees shared their insights on bullying, suicide, and the relationship between the two, and offered recommendations on community-led approaches to address these issues. SIPCW will use these recommendations as a roadmap to engage partners from various sectors in affecting systemic changes in the way that families, schools, and communities address bullying and suicide.

During the KIIs, the experts identified

specific risk and protective factors that contribute to bullying and suicide. Identified risk factors for bullying included low sense of self-esteem and self-worth, weak social support systems, and could coincide with belonging to one or more marginalized groups based on sociodemographic factors like age, race/ethnicity, sexual orientation, gender identity, disability, and family income. Identified risk factors for suicidal behaviors included feelings of sadness, hopelessness, depression, anxiety, and social isolation, past suicidal behavior, history of substance use, loss of a loved one, and barriers to accessing mental health and other supportive services. A young person's home life, including if there is a family history of mental illness or substance use, negative parent-child relationship, and/or involvement with child services are also important factors to consider. It may not be any single factor that causes a child to exhibit suicidal behaviors, but rather, the aggregation of several factors.

When discussing protective factors against bullying and suicide, the shared overlap in these protective factors was apparent, namely strong resiliency and problem solving skills, a strong support system that fosters a sense of connectedness, and adequate access to mental health services. The following recommendations were identified through the KIIs and focus

on strengthening these key protective factors by giving youth the skills to navigate challenging situations like bullying and suicide and affecting environmental strategies that focus on changing the community landscape.

*Building resiliency and problem-solving skills:* Strong coping, resiliency, and problem solving skills equip children to navigate and communicate through challenging situations. By adopting and implementing formalized Social-Emotional Learning (SEL) curricula early in a child's development (during elementary and middle school), children will develop the social emotional regulation skills they need to meet life's challenges and thrive in their social and learning environments. SEL provides a strong foundation that enables children to identify and understand their own feelings, regulate their emotions, effectively communicate their thoughts and feelings, and assess situations to respond appropriately. By developing these SEL skills early on and reinforcing this instruction throughout their development, generations of youth will learn to treat themselves and each other better.

*Empowering bystanders to stand up against bullying:* Bystanders may feel helpless and unsure of how to stop bullying, or they may fear that by stepping up,

*see Bullying on page 28*

### Bullying from page 27

they could become the bully's next target. Strong SEL skills will help youth to feel more empowered to help their peers, but it is still necessary to provide the appropriate skills to de-escalate tough situations when faced with bullying. Bystander intervention trainings at school can help to build these skills and show youth how to support others in solidarity.

Teachers and other school staff can also benefit from these trainings. Since they interact with students on a daily basis, they should be considered frontline staff in identifying and addressing bullying. As trusted adults, they should be empowered to intervene whenever they see any child being bullied or treated unkindly, and be aware of the mental health resources available at school to connect students to additional support. School staff need to reinforce these bystander intervention skills with their students whenever possible, and can do so by establishing norms around caring for and respecting one another, both in and out of the classroom.

**Promoting family and community connectedness:** Families do not always have the right tools to support their children emotionally, and could benefit from resources that reinforce family connectedness through strengthening key parenting skills. These parenting skill programs will build caregivers' knowledge of healthy and age-appropriate child development, effective communication methods, behav-

ioral management, and conflict resolution. Such programs will help caregivers develop and improve critical skills in fostering a nurturing and supportive environment for their children, which studies have shown to be effective in reducing adolescent risk behaviors like bullying and suicide (Devid-Ferdon et al., 2016). Caregivers who can help their children work through challenges in a productive way can foster resiliency skills that will help in navigating, and hopefully, preventing, bullying and suicide.

Community-based programs should be safe and inviting spaces where all young people are accepted. These should be spaces where young people can build themselves up, feel valued and appreciated, interact with peers and mentors, and feel comfortable sharing their personal challenges. In stressful times, the connections forged through these communities can be critical lifelines to socioemotional support. One clinician emphasized that "if they are building themselves up, they'll be too busy to let others bring them down," stressing that these programs help to build resilience to weather the shock of external trauma like bullying. It is important to engage school - and community-based leaders like teachers, team coaches, and faith-based leaders, who are already working with youth, and train them to be ambassadors for general wellbeing and mental health. By providing school staff and community leaders with the skills to identify behavioral health challenges like bully-

ing and suicidal ideation, and supporting them in helping these young people, we can reach youth with the support they need in more non-traditional spaces.

**Building Pathways to Access Mental Health Services:** SBHC clinicians noted how each school's mental health resources and capacity can differ widely, and may not necessarily be equipped to meet the needs of all students. SBHC clinicians may be adept at screening for mental health needs and making referrals to school- and community-based services, but oftentimes, there are not enough resources in schools and communities to meet students' needs. For short-term mental health support, school social workers can provide services, but long-term treatment plans are not possible. All SBHC staff that we spoke with acknowledged the overwhelming shortage of local mental health providers, which poses a major barrier to treatment. Agencies simply do not have adequate staffing and resources to respond to all these urgent cases in a timely manner. Wait times for an appointment can take months, which strains the healthcare system and frustrates parents, children, and clinicians.

Increasingly, the task of managing mental health treatment is falling onto physician generalists, both in school and community settings, but they do not always have the confidence or comfortability to manage patients' mental health needs, especially cases involving suicidal ideation. SPCW recommends additional professional development for pediatri-

cians to build confidence and competency in addressing milder cases to relieve pressure from the overstretched mental health outpatient clinics. Increased collaboration between pediatricians and psychiatrists through case conferencing would support exchange of best practices and facilitate more seamless patient-centered care. Additionally, the emergence of telehealth offers opportunities to close some of these gaps in services, and providers should be supported in building their tele-capacity moving forward.

Addressing the existing culture of bullying requires a community-wide realignment with a thoughtful, strategic approach. All stakeholders need to work collaboratively to address this deeply entrenched bullying culture through evidence-based strategies as a means to prevent suicides. If we can change the community norms around bullying and suicide through collective action, we can improve mental health and wellbeing for future generations of young people.

For more information, reach out to Maralie Deprivil ([maralie@sipcw.org](mailto:maralie@sipcw.org)) or visit [www.sipcw.org](http://www.sipcw.org).

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### Zero Suicide from page 22

as a systems issue rather than blaming of individual staff members and solely focusing on liability issues. TRAIN is the second implementation element (develop a suicide prevention competent workforce). Finally IMPROVE (data driven quality improvement) is the third implementation element. These elements emphasize the necessity for everyone in the system to receive excellent suicide risk training and also learn the most effective strategies for interacting with a suicidal population. In addition, data collection creates additional assessment of progress and informing necessary revisions. The four clinical elements include: IDENTIFY (screening and assessment of suicide risk), ENGAGE (ensuring pathways to care), TREAT (using effective evidence based best practices and TRANSITION (continuing contact and follow-up).

As of April 1 2017, 177 mental health

clinics have elected to participate in the implementation of the ZS model (Labouliere, et al., 2018). The National Institute of Mental Health (NIMH) has funded grants evaluating the efficacy of the ZS model. This is the most significant implementation and evaluation of ZS that has yet to be conducted. This essential work serves as a continuous quality improvement project undertaken by the NYS Office of Mental Health Bureau of Evidence Based Services, with funding from the NIMH to test and evaluate implementation strategies.

NYS has served as a test system for outpatient ZS research. New York was chosen, because it is representative of standard outpatient care across the United States. Few outpatient behavioral health clinics have established systematic protocols for identifying, treating, and monitoring patients at elevated suicide risk. There is also no universal protocol for documenting and sharing information across treatment settings (NYS Office of Suicide Prevention, 2016).

### AIM-SP

All of the participating clinics are implementing the operationalization of ZS procedures. This abbreviation stands for Assess, Intervene and Monitor for Suicide Prevention. It is structured to provide basic care, including universal screening and comprehensive risk assessment regularly, as well as engaging high-risk patients with individualized care and increased contact with their outpatient behavioral health team.

All patients are screened for risk at intake, as well as quarterly treatment plan review and on an as needed basis using the Columbia Suicide Severity Rating Scale (C-SSRS; Posner, et al., 2011). This reliable rating scale measures current and past suicidal ideation, suicide attempts, preparatory behaviors as well as non-suicidal self -injury (NSSI). Brodsky, et al., 2018 define NSSI as a deliberate self-harm behavior performed with no intent to die (Brodsky, et al., 2018).

Suicide specific psychosocial treat-

ment (CBT and DBT) as well as following the APA practice guidelines for suicide are used to incorporate Identifying risk and protective factors. There is a careful review of demographics, psychiatric family history, diagnosis, trauma and protective factors to target precipitants to self-harm. The goal continues to be preventing post-therapy attempts and real attempts, decreasing hospitalization and decreasing emergency department visits.

We are seeing important micro and macro level changes that are inspiring and increase our feelings of hope moving forward. David Covington with Dr. Michael Hogan, former NYS Commissioner developed the Zero Suicide Initiative. (Covington, et al., 2019) has described ZS as the dogged pursuit of perfection in healthcare leading to remarkable success at reducing the number of lives lost to suicide in health care systems.

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### The Suicide Crisis from page 1

experience of discrimination, prior suicide attempts (although 60% of suicide decedents have never previously attempted suicide), family or spousal history of suicide, and a history of childhood trauma or being bullied.

According to the interpersonal theory of suicide, two critical factors are a lack of “social connectedness” and a sense of “burdensomeness.”

The more risk factors, the greater the risk, but completed suicides are statistically rare even among people with several risk factors.

#### Why are Suicide Rates Rising and What Can be Done About It?

There are two broad but not mutually exclusive perspectives from which these questions can be answered—clinical and sociological.

**The clinical perspective** on suicide is based on the fact that about 90% of the people who complete suicide suffer from a mental illness, usually an affective disorder, especially major depression. There are also high rates of suicide among people with schizophrenia (especially during their first psychotic break), substance dependence (especially alcohol or opioids), or PTSD (especially veterans).

Does the rising suicide rate reflect rising prevalence of these mental disorders or a decline in treatment? There is some evidence that the prevalence of mental and substance use disorders has risen, but so has percentage of Americans getting treatment. It is likely, however, that much of the increase in treatment is of people without a diagnosable disorder that suggests risk of suicide.

Despite the ambiguity of epidemiological evidence, there is widespread agreement that rising suicide rates reflect failures of the American behavioral health system.

Some mental health advocates make the broad claim that rising suicide rates are the outcome of deinstitutionalization, i.e. of reducing psychiatric hospital beds without providing adequate alternatives in the community. The problem with this claim is that suicide rates declined in the United States during the peak years of deinstitutionalization. That notwithstanding, some argue that the reduction of psychiatric hospital beds has reached a tipping point and that now more are needed.

Another line of thought concludes that rates of suicide declined when anti-depressants were introduced and that rates of suicide increased when a warning was issued about potentially deadly side-effects of anti-depressants. The problem with this point of view is that overall the use of antidepressants has increased while



**Paul S. Nestadt, MD**

suicide rates have been rising. It may be, however, that they are being used by people who have low suicide risk while use by people with higher risk has diminished. Advocates of this perspective call for more targeted use of anti-depressants.

Many behavioral health advocates are skeptical about claims that more meds or beds will bring down suicide rates. But virtually all mental health advocates agree that tremendous improvements in the nation's mental health system are needed. There was strong support for the recently legislated creation of a 988 number for psychiatric crisis intervention. And there is also strong support for enhancing the capacity to provide access to quality of behavioral health services.

There is also widespread agreement that identification of suicide risk needs to improve. Considerable attention focuses on primary care physicians because 45-70% of people who take their own lives have been to the doctor within thirty days of their suicides. Would more screening by physicians make a difference? There is some debate about the value of screening specifically for suicide risk because these screening instruments reveal suicidal ideation but not the likelihood of completing suicide. Because of the relative rarity of completed suicide, these screeners are plagued by false positive screens for suicide, as well as unacceptable levels of even more tragic false negatives. Still, there is general agreement that screening for depression and substance abuse could be helpful. (Failure to screen, of course, does not explain the rise in suicide rates since doctors were certainly not screening for suicide when suicide rates were lower.)

Suicide prevention advocates also call for better training of behavioral health professionals and other health and human service providers not only in identification



**Michael B. Friedman, LMSW**

of suicide risk but also in management of risk. Traditional efforts of distinguish between serious suicide risk and suicidal thoughts not likely to result in attempts focused on questions such as whether the person had a plan and the means to complete suicide. That is important, but it is now known that most suicides are impulsive. So, the key appears to be developing a safety plan that helps a person considering suicide not to attempt it if the impulse becomes strong. Very importantly, this involves limiting access to the means of suicide, especially guns. Training in this shift in orientation about people with suicidal ideation could make a significant difference.

Clinicians, of course, have a responsibility to take protective action if a patient is a clear and present danger to self or others. What they should do depends on the circumstances, and legal requirements vary from state-to-state. Call 911, call a mobile crisis team, make a report of dangerousness to a local authority, call for removal of weapons from the home, begin an inpatient or outpatient commitment procedure? It is not clear that behavioral health and other health and human services professionals working in community settings are well-informed about what actions to take, or even the extent of their legal tools as written in their own jurisdictions.

**The sociological perspective** on suicide has a long history harking back to Emile Durkheim, who studied suicide rates at the end of the 19th century. He identified a number of sociological factors that increase the risk of suicide, most famously “anomie.”

Social determinants of mental and substance use disorders and of suicide have become an increasing focus of concern in recent years. For example, considerable attention has been paid to the ease of ac-

cess to guns in the United States and to the apparent link between economic circumstances and suicide rates.

There is strong evidence that states without meaningful gun control laws have higher rates of suicide than states with such laws even after controlling for important differences such as rurality and race. This leads most behavioral health professionals to call for strong gun control measures.

There is also historical evidence that suicide rates rise and fall with the economy. But in the United States the current rise in suicide rates does not seem to be closely linked to the economy. Yes, suicide rates went up during the great recession that began in 2008, but they continued to go up as the economy grew stronger. In addition, in the European Union, suicide rates have trended down since the turn of the century even though the vicissitudes of their economies have paralleled those in the United States.

Ann Case and Angus Deaton have developed an interesting theory that links economic factors to what they call “deaths of despair.” The link, they say, and the reason for the declining life expectancy in the United States even before the pandemic, is not between suicide and the overall economy but between it and a particular subpopulation that has rising rates of suicide, drug overdose deaths, and alcohol-related deaths. This subpopulation consists of white working age men with no more than a high school education—a subpopulation that is increasingly closed out of upward mobility or even economic stability in America. In their most recent book, they link “rising deaths of despair” with failures of capitalism and call for progressive social change in America. It is interesting that they have been criticized for failing to identify People of Color and women as part of the population in despair in America.

There are other theories of social causes of suicide. For example, Julie Phillips notes that the rise of suicide in America has taken place especially among the Baby Boom generation. Raised with a promise of happiness, this generation may be more vulnerable to disappointments. Other possibilities include a growing sense of disconnectedness and dislocation in a society marred by vast economic, racial, and political divides. Or perhaps a loss of traditional values and sources of meaning as reflected in the decline of participation in religious institutions is driving despair and suicide. Or perhaps it is changes in family culture—fewer marriages, more mobility, less acceptance of a responsibility to care for one's own. Or perhaps it is the significant rise in social isolation, or despair about the state of the world and the future of the human

*see The Suicide Crisis on page 31*

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### *Veteran Suicide from page 14*

Army Captain and current Clinical Psychology Pre-Doctoral Fellow. Both virtual presentations are CME-accredited and will be recorded and made available on the NYSPA website in the Fall 2020.

NYSPA's VMH-PCTI presentations, originally designed as one hour in-person trainings, have been presented at teaching hospitals and other educational settings as well as off-campus venues. These virtual presentations and recordings are ongoing, while NYSPA will resume in person presentations when federal and state guidance indicates it is safe in light of the COVID-19 pandemic. In addition, NYSPA partnered with the Medical Society of the State of New York and the New York Chapter of the National Association of Social Workers to host several VMH-PCTI conferences consisting of dozens of presentations for community mental health providers as well as primary care specialists. The VMH-PCTI is made possible by grants from the New York State Legislature and is administered through the New York State Office of Mental Health. The VMH-PCTI is an important component in addressing a recommendation of Governor Cuomo's Suicide Prevention Task Force and its 2019 report that call on State agencies to "... coordinate to develop a curriculum for health-care workers to increase their understanding of the unique needs of the Veteran population."

**Learn about VA Suicide Prevention Resources.** The VA launched general programs and services to prevent Veteran suicide that include the provision of Sui-

cide Prevention Coordinators at each VHA facility to monitor at-risk patients, development of a suicide hotline specifically for Veterans, design and implementation of a medical records-based algorithm to identify high risk Veterans and extensive suicide prevention research portfolio (see the 2019 National Veteran Suicide Prevention Annual Report, pp. 28-29, for a comprehensive list). These efforts produced significant improvements in the care and treatment of high-risk Veterans and decrements in the suicide rate of Veterans who seek VA care.

**Become Aware of State and National Veteran Suicide Prevention Efforts.** Prompted by escalating suicide rates in Veterans, recent legislative action at the federal level includes the passage of the Clay Hunt Suicide Prevention for American Veterans Act (2015) and 'President's Roadmap to Empower Veterans and End the National Tragedy of Suicide' (PREVENTS) task force charged with focusing on community engagement strategies (Executive Order 13861, 2019). This order encourages federal government, academia, employers, members of faith-based and other community, non-governmental, and non-profit organizations and the Veteran community to all work together to develop a strategy that will truly impact the current epidemic faced by Veterans. Funding opportunities are still in development and will hopefully be announced later in 2020.

Additionally, the Mayor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families run by the Substance Abuse and Mental Health Services Administration (SAMHSA) and

the VA provided 24 cities across the nation, information, resources and support for addressing Veteran suicide at the local and community level. This evolved into the Governor's Challenge, launched in February 2019 in seven states. New York State participated in the second round of the Governor's Challenge and is in the process of building its proposal. Elements will include projects to help better identify at-risk Veterans, programming targeting Veterans upon leaving military service and projects aimed at gun safety and lethal means safety trainings for clinicians, family and others who interface with Veterans.

**Expand your use of Lethal Means Safety.** One of the best ways to reduce suicide rates is to more effectively implement lethal means safety techniques and strategies. As firearms is associated with over 70% of Veteran deaths, asking patients about gun ownership, gun access and storage, use of gun locks, plus involving loved ones in the discussion if necessary, can be life-saving. Consider additional training by taking a "Counseling on Access to Lethal Means" (CALM); a two hour workshop accessible at [www.sprc.org](http://www.sprc.org).

With the impressive increase of collaborative efforts, fostering of community partnerships, education efforts across the population and public messaging campaigns raising awareness about Veteran suicide, we can make a difference.

The following is additional information regarding New York's Veteran population. New York has the fifth largest Veteran population in the U.S. with 838,000 Veterans living in the State (NY Health

Foundation, 2017). Approximately 93% of NY's Veterans are men and approximately 7% percent are women. The Veteran population of women Veterans is expected to top 10% by 2025 (NY Health Foundation, 2017). The National Center for Veterans Analysis and Statistics provides a further breakdown of the Veteran population in NYS by age group (Department of Veterans Affairs National Center for Veterans Analysis & Statistics, 2014): 18 to 34 year olds – 6.6%; 35 to 54 year olds – 20.0%; 55 to 64 year olds – 16.8%; 65 to 74 year olds – 27.0% and, 75 years and over – 29.5%. The period of service for NY's Veterans (NY Health Foundation, 2017) is as follows: World War II – 51,000 (6%), Korea – 91,000 (11%), Vietnam – 269,000 (32%), Gulf War Era – 219,000 (26%) and, Post-9/11 only – 94,000 (11%). Out of New York's 62 counties, the five with highest population of Veterans: Suffolk with 72,000, Erie with 61,000, Nassau with 52,000, Queens with 50,000 and Kings with 46,000 (NY Health Foundation, 2017).

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## If You Are Feeling Hopeless, Call the National Suicide Prevention Hotline: 1-800-273-8255

### *Care Transitions from page 21*

there exists a push and pull tension between having so many places to choose from to get help and stringing services together in one integrated setting.

#### Do Not Miss the Moment

The COVID-19 pandemic is devastating many people's lives and wellbeing. The increased risk and uncertainty having elevating effects on feelings of anxiety, depression and/or suicide, especially for people who are already vulnerable to behavioral health conditions. Calls to the National Alliance on Mental Illness' (NAMI) HelpLine are up 65% in comparison to a year ago.

The pandemic has caused the field to make remarkable speed and progress in transitioning to virtual appointments. Where it has led to more access to care and getting care, telehealth is working effectively for many. However, it involves a different framework that is more complicated with the use of caring contacts.

So, let us strengthen and buildup the system to function as a true continuum of care that can prevent suicide and other deadly maladies. There is excellent evidence on when, where, and how we can make a difference in the number of suicides and people returning to emergency departments and inpatient facilities. Hospitals, emergency departments and crisis centers can implement Safety Planning Interventions (SPI). Certified Community Behavioral Health Clinics (CCBHCs) are already required to have formal partnerships with inpatient and outpatient providers, 24-hour crisis response services and serve people regardless of their ability to pay.

In creating a more integrated, neighborhood-based safety net that connects all parts of the service delivery system, there are several cost-effective measures for suicide prevention upstream. This may hold the greatest promise for saving the greatest number of lives: inpatient and outpatient working as a collaborative team and maintaining connections with individuals during care transition to ensure continuity, shared responsibility and that somebody else out there cares.

### *Problem Gambling from page 27*

problem gambling. It can be very difficult to spot, so it may be difficult to know if someone is struggling with this and may be having suicidal ideations. While there are no physical signs, there are still signs to look for if you think someone may be struggling with a gambling problem. Some things to look for are:

- being absent from friend/family events because of gambling,
- feeling stressed or anxious when not gambling,
- low work performance due to absence or preoccupation with betting, and
- lying to family and friends about how much money and time is spent on gambling.
- relying on others to get out of debt, asking for loans or bailouts
- using money needed for necessary expenses, such as food, rent, or medication for gambling

While we cannot physically test for problem gambling, there are screening and diagnostic tools that can be used to initiate a conversation about gambling. A common tool to use is the Brief Biosocial Gambling Screen, or the BBGS. It is a simple three question screen that consists of yes or no answers.

• During the past 12 months, have you become restless, irritable or anxious when trying to cut down on gambling?

• During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?

• During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?

If you, someone you know, or a client you work with answers yes to any of these questions, it may be time to start talking about problem gambling. Problem gambling can affect anyone at any point in their lives and can impact friends and families of those struggling with their gambling. It can develop into a gambling disorder, which leads to damaged relationships with loved ones, difficulty at work, and financial problems. These problems can be detrimental to an individual's mental health. It is important that we start to realize the importance of talking about problem gambling, and what impacts it may have on individuals. If we take the time to educate ourselves and start the conversation, we can help break the stigma and shame out of problem gambling and get those struggling the help that they need. If you or someone you know is struggling with problem gambling, they can visit [NYProblemGamblingHELP.org](http://NYProblemGamblingHELP.org) to find out more and get connected to resources.

“From the ashes a fire shall be woken, A light from the shadows shall spring; Renewed shall be the blade that was broken, The crownless again shall be king.”

J.R.R. Tolkien, The Fellowship of the Ring

### The Suicide Crisis from page 29

species. It will certainly be interesting to see whether suicide rates rise during and after the pandemic, which brings its own set of anxieties, new levels of isolation, economic turmoil and unemployment, an increased rate of gun ownership, and grief both for a lost way of life and more concretely for lost loved ones.

#### What To Do?

**Clinical Improvements:** There is widespread agreement that whatever the cause of rising suicide rates, reversing the trend requires improving both the physical and behavioral health systems. This would include:

- Establishing a 988 number to call instead of 911 in a psychiatric crisis
- Improving identification and treatment of mental and substance use disorders in primary health care

- Improving the response to demoralizing health conditions
- Improving pain management using non-opioid interventions
- Improving integration of the physical and behavioral health care
- Increasing capacity, access, and quality in the behavioral health system
- Increasing the use of safety plans for people considering suicide—including safe storage or removal of guns
- Increasing early intervention for people experiencing their first psychotic break
- Enhancing outreach to populations at high risk of attempting or completing suicide
- Increasing public education to combat stigma, to increase public understanding of behavioral health, and to increase knowledge of how to get help.

**Societal Interventions:** Given the social determinants of behavioral health problems in general and suicide in particular, it is important to work towards social change as well as clinical improvements. This is especially critical after recognizing the inadequacies of our current individual risk assessment tools. A public health approach, intervening at the population level, is vital.

Perhaps most importantly this includes efforts to reduce access to guns. But it should also include efforts to reduce social isolation; address poverty, disparity, and discrimination; address economic structures that result in disconnection from opportunity as well as access to care; address social divides that result in disconnection; and even try to address the human need for meaning.

#### Challenges and Opportunities of the Pandemic

Suicide, though a continuing epidemic, has fallen under the shadow of the pandemic, which now, and for good reason, draws attention away from most other

health-related issues. The pandemic, at this writing, has caused twice as many deaths in half a year as suicide did in all of last year. But the pandemic has also had psychological fallout that has created great concern and has produced innovative interventions such as tele-health and outreach to combat social isolation and more. Perhaps, these innovations will facilitate connections with people at high risk of suicide both to counter their isolation and to make treatment more accessible.

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### Campus from page 24

meanwhile, have the authority to increase access to services and resources on campus, promote their availability, and encourage students to use them. One such service is Crisis Text Line, a free, 24/7 texting service in which students, faculty, and staff can anonymously text with a trained counselor about issues related to depression, anxiety, suicidal ideation, substance misuse, relationship problems, domestic violence, and stress and anxiety resulting from the COVID-19 pandemic by simply texting “Got5U” to 741-741. Administrators, faculty, staff, and students may promote the availability of these services with publicly available, college-specific [marketing materials](#). Administrators can also choose to add Crisis Text Line information along with other campus-specific resources on the backs of student ID cards so that these resources are readily available to all students at all times.

*Train the Campus Community to Identify Suicide Risk and Refer to Services.* Students, faculty, and staff are all gatekeepers alike, coming in contact with others on a daily basis who may be at risk of suicide. Evidence-based trainings such as Question, Persuade, and Refer (QPR) are designed to educate people about the myths of suicide, warning signs, and ways to persuade suicidal individuals to seek help. The online, self-paced QPR course [is available free of charge](#) to campus communities across New York State. Lim’s conclusions, while perhaps well-meaning, contradict the facts. Everyone has a role to play in preventing suicide. Increasing access to training will provide students,

faculty, and staff with the knowledge and skills required to make an impact.

*Practice Intersectionality.* Certain groups are at higher risk for suicide including those identifying as Lesbian, Gay, Bisexual, or Transgender (LGBTQ+), Native Americans, and veterans. In addition, suicide attempts among Black adolescents increased 73% between 1991 and 2017 (Lindsey et al., 2019), and Black Americans have seen a spike in depression and anxiety following the recent tragedy of George Floyd earlier this year. Asian Americans are the least likely racial group to seek mental health services. Understanding the weight of overlapping risk factors will help not only to develop intersectional solutions but also to build community and empathy.

Provide Virtual Access to Services and Resources. The COVID-19 pandemic has changed day-to-day life, emphasizing the need for virtual services and resources that support mental health. This has already been demonstrated in the shift towards telehealth through college health centers. In addition to this, it is important to ensure that other services and resources remain available to students in a virtual environment including club connections and faculty/staff mentorship. And again, raising awareness of the availability of Crisis Text Line and how simple it is to text “Got5U” to 741-741 for immediate, 24/7 support can play a central role in this strategy.

*Perspective from Brett Harris, DrPH, Clinical Assistant Professor, University at Albany School of Public Health:* As an alumna of Cornell University, I am very familiar with the role that colleges and universities play within their larger geo-

graphical communities. Cornell, located in Tompkins County, is the central hub of the county along with Ithaca College and TC3. When I was a student at Cornell, I worked on a longitudinal research project with a professor for which I traveled a two-hour radius from Cornell to interview adolescents and their parents in their homes. As a student insulated within a largely diverse, almost metropolitan university setting, it was eye-opening to see how only a few minutes’ drive from campus, and for hours thereafter, the demographic makeup, population size, and geography changed to vastly rural and low-income.

Rural areas are disproportionately impacted by suicide. According to data from the Centers for Disease Control and Prevention, the suicide rate in rural New York is significantly greater than the state average (13.1 vs. 8.3/100,000) and increased at a greater rate between 2000 and 2018 (47% vs. 40%). To explore ways to support rural communities across New York, I assembled a research team at the University at Albany School of Public Health – including interns Catherine and Juliana Rich from Cornell – to conduct a New York Rural Mental Health Listening Tour. The overall goal of the project is to increase our understanding of the unique characteristics of rural communities that may contribute to mental health concerns and increased risk of suicide. Through conversations with local Directors of Community Services, other behavioral health stakeholders, and general community members, we have learned that no statewide or regional approach will sufficiently mitigate the risk of suicide. Each county faces unique challenges – which is

why it is critical to listen to each community and work to understand the varying forces at play.

Our listening tour consists of two forums per county: one with behavioral health stakeholders and one with community members at-large. We have forums planned in multiple counties this fall including Essex, Clinton, Franklin, St. Lawrence, and Wyoming, and Yates counties and plan to recruit additional counties in the spring. Once each set of forums is complete, we will develop a county-specific report and set of recommendations that we will share and discuss with each county.

*Conclusion:* Suicide is a significant public health problem that is often amplified by context. We presented the institution of higher education and the rural geographical context in this article, but there are many others that underscore the importance of a comprehensive approach to suicide prevention. What we know, what gives us hope, and what drives our efforts is that suicide is ultimately preventable. This alone can guide us in overcoming challenges and striving toward mental wellness within our communities.

If you are in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or contact the Crisis Text Line by texting “Got5” to 741-741.

*Catherine Choi is a Student at Cornell University, and Brett R. Harris, DrPH is Clinical Assistant Professor at the University at Albany School of Public Health. For questions or comments related to this article, please address correspondence to Brett Harris, DrPH at [bharris@albany.edu](mailto:bharris@albany.edu).*

### Using Local Data from page 18

suicide-specific treatment tools into our training and workflows. We are expanding our joint training with agencies that serve those impacted by family violence. Community education has been a high priority for us, as evidenced by our ongoing Com-

munity Conversation series that has addressed multiple aspects of suicide and its impact on families and the community; by our delivering safeTALK and ASIST for the general community as well as by delivering site-specific training at businesses, in school communities and at other sites. Providing community education on this sensi-

tive topic is challenging during the COVID-19 restrictions. However, as the need for these conversations and training continues, we are exploring ways to safely deliver suicide awareness and prevention training through virtual platforms.

September is Suicide Prevention Month. This year especially, as our com-

munities experience an increase in multiple stressors associated with heightened risk of mental health challenges, substance use and risk of suicide, it is fitting that our SFRT will hold its first formal review. We are optimistic that as in Oregon, our work will achieve a significant reduction in lives lost to suicide.

### Latina Teens from page 20

Rico, Mexico, Ecuador, Columbia, Honduras. The criteria for participation in the LIP program is that youth must have a psychiatric diagnosis, is receiving psychiatric and/or mental health services, attending school and have parental consent.

LIP fills a gap in the delivery of mental health services for the Latinx population. Incorporated into LIP intake is our Multi-cultural Relational Approach for Diverse Populations™, which integrates awareness of – and sensitivity to – clients' cultural beliefs and preferences into all aspects of service delivery; it promotes youth choice, youth strengths, family participation and resources. This approach successfully moves our participants emotional and behavioral challenges towards greater resiliency, personal stability, independence, health and wellbeing.

As the Latinx population in New York City (29%) and throughout the United States continues to grow, it will become even more vital for there to be programs specifically designed for this often-marginalized population of immigrant communities. In the wake of the Covid-19 pandemic, this need increased even more.

#### Program Model

Comunilife embraces a culturally competent and gender responsive approach to the work. Our approach includes comprehensive, holistic case management services, youth development groups, academic support, creative arts therapies, music, civic engagement, health/wellness activities and supportive family services.

Each of these components, promotes emotional growth, development of coping mechanisms, healing and a strong sense of community. In essence, these trauma-informed activities create a language used to communicate thoughts, feelings, experiences and states of being. Through this process, the participant with the guidance of LIP staff, develops a personal vocabulary and uses this learned

language to communicate those states of being that can defy verbalization and containment in order to gain insight and coping skills.

The programming Comunilife implemented is integral to achieving LIP's program philosophy of "Survive, Strive and Thrive". This means that LIP must be a safe place in which to receive support (survive), offer activities that allow the teens to develop their unique voice (strive), and provide tools that help the teens envision and achieve goals (thrive).

For our Spring and Summer 2020 Program, which was conducted remotely due to the COVID-19 Pandemic, we created "Unity" groups, where participants from all four program sites (Bronx, Brooklyn, Queens and Manhattan) were invited to participate together in the groups facilitated by LIP case managers and the music and art therapists. The goal was to enhance and build upon our LIP community and connectedness among peers.

Family Engagement continues to be a cornerstone of our work at LIP. Our more than 12 years of experience has taught us that working with the whole family is essential to a young person's healing and development.

At the beginning of the Covid-19 Pandemic, which disproportionately impacted the families we serve and the communities in which they live, we developed a new weekly (Spanish language) parent support group to help families navigate the crisis. Each week, we developed interactive and supportive conference calls to provide extra support and aimed to help Caregivers identify and implement coping mechanisms for themselves and for their family members.

The weekly groups have given the parents an opportunity to build a supportive community where they can speak with one another about their experiences and struggles and get holistic support and strategies to manage and navigate stress, anxiety, depression and suicidal ideation for themselves, their daughters, and their family members. Through this collective experi-

ence, we are building a strong sense of togetherness and solidarity and have provided our families with an opportunity to process and heal from this and past trauma as individuals, as a family and as a community.

During these family support groups, many of the caregivers expressed a desire to learn English. LIP then implemented twice weekly ESL classes for parents with the aim of decreasing their stressors and making them stronger candidates for job opportunities as well as enhancing their communication with school administrators, teachers, therapists and psychiatrists.

In the last five months, since the onset of the Pandemic we have found that:

- Over 90% of the parents have either lost their jobs or have had their hours reduced.

- 100% have expressed concerns over food insecurity. LIP received a grant from the Hispanic Federation to provide \$300 gift cards for the families to be used for food and household items.

- Many families are dealing with loss and grief and fear of the unknown

As a result of our enhanced parent involvement, caregivers reported that they felt better equipped to manage their daughters' symptoms during this time and implemented the psychoeducational and practical tools and techniques they have learned.

#### Program Outcomes

In 12 years of programming, not one Latina teen who has participated in LIP has completed suicide. LIP's accomplishments are measured by the positive results achieved by the girls. This is validated by an evaluation which has been conducted, since 2013, by the New York State Psychiatric Institute/Columbia University - New York State Center of Excellence for Cultural Competence. The research has shown that for every month a Latina teen participates in Life is Precious™ her level of sui-

cide ideation and depression decreases. For Latina teens with a history of sexual abuse and/or drug and alcohol use, the decrease in suicide ideation and depression were more profound. Comunilife's goal is to have Life is Precious™ designated as a community informed, evidenced based practice model of care by SAMHSA. The researchers have completed phase one of the evaluation where fidelity testing took place and a manual of operations was developed. Phase Two, which is working with control groups, is currently in process.

We know that LIP is achieving these successful results for the following reasons:

- 1) LIP is a community informed program which directly addresses the risk factors associated with Latina adolescent suicide

- 2) LIP provides culturally competent services that integrate cultural norms into all program development

- 3) LIP incorporates the entire family to reduce the risk of suicide among Latina teens.

#### Conclusion

While we know that the pandemic will have long lasting effects on the lives of our teens and their families and know that they will continue to face this crisis for some time, we have learned new ways in providing support and staying connected to create a sense of community, hope and stability in which our families can thrive.

*Comunilife's mission is to provide vulnerable communities with housing and culturally sensitive supportive services. Our vision is that no one should be without the housing and support they need to lead a healthy, meaningful life.*

*Julie Laurence, LMSW, is Senior Assistant Vice President for Life is Precious; Beatriz Coronel, MA, is Senior Program Director Life Is Precious; and Rosa M. Gil, DSW is Founder, President, and CEO at Comunilife, Inc., (917) 304-3645.*

### Solutions from page 8

begin with, we instituted rapid admissions processes for clinic and treatment services for those at highest risk.

With the reality of people being forced to stay home, we shifted most services to a telehealth model. This proved to be a very effective shift, particularly for those living with the more serious mental health conditions and particularly those at greatest risk for suicide. We had a vehicle that could offer immediate help.

We knew that clients prone to depression and living alone, might become increasingly paranoid when forced to quarantine in their apartments. This also caused deep concern about a spike in substance use and an exacerbation of psychiatric symptoms, even to the point of showing suicidal ideations or to suicide. Knowing which clients might be easily triggered during this period allowed us to make a concerted effort to ensure that regular wellness checks through home visits continue. ICL staff are often a person's only human connection so doing these visits continued for those most isolated; always with full adherence to safety precautions and use

of personal protective equipment.

The upside of our experience in addressing the impact of COVID was the realization of just how useful telehealth could be, especially for people with multiple health problems. In fact, compliance with appointments increased significantly: From March to May, the percentage of ICL clients who failed to keep medical appointments dropped from 33% to 15%. Using telehealth has also allowed us to triage health issues in our residences so clients did not have to travel to appointments that required accompaniment by two staff, resulting in a reduction in costly emergency room visits that also frees up medical personnel to meet the demands of COVID patients.

Shifting overnight to telehealth was our clear imperative but also extremely challenging. Our IT department spent the first weekend preparing 600 new laptops for clinicians to conduct remote services. And doing treatment remotely necessitated special staff training including how to deal with issues putting clients in any danger, such as a sign of suicidal thoughts or ideations. An ICL clinical team produced a manual (see below) with tips and strategies for staff to have

at their fingertips and ideas for self-care, to support the "helpers" living with the new realities of COVID.

It was not only staff who found telehealth very useful; clients felt very positively about these services. The proof is in the numbers. ICL conducted a survey since the pandemic began, of almost 1,500 clients that showed high satisfaction with telehealth. Many of them even prefer it to visiting a clinic and 80% said they want to continue remote appointments after the pandemic.

Of course, remote services are not the solution for all clients; in fact, for many attending an ICL program (at a physical location) is a lifeline. A good example is our PROS program which offers comprehensive, outpatient treatment and support to people living with serious mental illness. A number of PROS clients came to our East New York Health Hub during the pandemic. The program was closed but the Hub where it is located, was open for them to visit if they needed the familiarity and some clients in the program's intensive art program continued to work with the art therapist on projects they'd started before COVID. For these individuals, art helps build a tremendous

source of confidence and stability that they themselves say is life-saving. In addition to having the chance to socialize and engage in activities, PROS often offers the only hot meal for people so staff made sure whoever needed it were fed. They also ensured clients were connected to longer-term solutions like food assistance programs and to benefits like unemployment insurance.

It is not only our staff and partner health care providers helping save lives during this crisis. ICL clients themselves are remarkably resilient. Long before COVID, clients worked on skills and tools through behavioral therapy and learning about healthy living. All of this work that's gone on since they got involved at an ICL program meant they were better able to manage their heightened emotions during the pandemic, helping to keep incidents low over the past few months.

The underlying goal of everything we do at ICL is to assure people they have a future and that our dedicate staff are with them every step of the journey. No matter what problem they may face or how troubled they may feel, we never give up on anyone.

### *All Hands on Deck from page 4*

high-risk time for suicidal individuals. One recent meta-analysis suggested the risk of suicide for those leaving inpatient behavioral healthcare is 200-300 times higher than the general population and even higher in the first few days (Chung 2019). Closing this deadly gap must be a priority. But again, effective programs can reduce this risk. In a study involving veterans presenting to EDs for a suicidal crisis, safety planning with follow-up engagement in the immediate post-discharge period was associated with a 40% reduction in suicide attempts and a higher rate of following up with outpatient care (Stanley et al. 2018). In NYS the OMH Suicide Prevention Office has been working with hospital systems across the state as part of a federally funded Zero Suicide grant to ensure patients at elevated risk are engaged following inpatient and ED encounters until connected to community supports.

OMH is piloting a first in the nation program called Attempted Suicide Short Intervention Program (ASSIP). ASSIP is a 3-session intervention for adults with a recent suicide attempt, a very high-risk group. The approach draws less on patient diagnosis and instead focuses on the patient's unique story to develop a safety plan based on factors driving the recent suicide attempt. In one randomized controlled trial ASSIP re-

duced repeat suicide attempts by 80% (Gysin-Maillart 2016). ASSIP is now available for adults in Syracuse and Rochester.

It is important to note that peers have an important role to play in advancing the Zero Suicide model in NYS. Beyond advocacy and the power that comes with having peer support in clinical settings, demonstration projects are planned for in NYS around peer training in safety planning and providing follow-up support for at risk individuals discharged from EDs and those newly released from jail.

To "bend the suicide curve" in NYS suicide prevention efforts in health and behavioral healthcare systems must be complemented by public health approaches (pillar 2) at the community level. Perhaps the best example of a public health approach is NYS' school-based prevention programs. In addition to being Suicide Prevention Month, September, of course, marks back to school. OMH continues to support robust school-based prevention in a number of ways, including expansion of school-based mental health clinics, development of a model school policy for preventing suicides, and providing a host of trainings for school staff. Over 21,000 school staff were trained since 2018 (see accompanying article on the next page by Dr. Jay Carruthers).

The third pillar of the NYS Suicide Prevention Plan is improving the accu-

racy, quality, and timeliness of the information used to guide our efforts across the state. While perhaps less visible than the work underway in healthcare systems, schools, and communities, sound data and surveillance are foundational. Without investments in this area, healthcare and community-based initiatives will not succeed. Surveillance data is crucial in recognizing populations at greater risk of suicide.

OMH is supporting an innovative program from Oregon in 4 NYS counties that highlights the power of robust community-level data leading to targeted interventions that save lives. The program has two main focal points: first, having medical death investigators capture key risk factors and circumstances data with every suicide death; second, assembling a group of community stakeholders, including law enforcement, healthcare providers, crisis workers and emergency medical services staff, to perform in-depth reviews of suicide deaths after obtaining consent from the legal next of kin. By allowing agencies to freely share information solely for the purpose of preventing future suicides, investigators were able to identify important trends in the data. One of the last things several decedents did, for example, was drop off their pets at animal shelters before killing themselves. Animal shelter staff have now been trained to recognize individuals at risk and connect them to supports and have already done so

several times. By using the broader suicide fatality review model—a model driven by actionable community-specific data, Washington County, Oregon has been able to reduce its suicide rate by 40 percent. In NYS, we have already collected data on close to 200 deaths in the 4 pilot counties and in-depth reviews are underway.

Finally, one of the most important tools we have in the war against suicide is spreading stories of hope and healing, especially in the current media environment where we are flooded with discouraging news and statistics. Research supports this notion that positive media messaging involving real stories of people growing and working through suicidality can be protective. It even has a name—the Papageno effect, named after a character from a Mozart opera, who when contemplating suicide was swayed after shown more positive ways of resolving his problems.

Despite the rise in suicide rates, there are a number of ways for each of us to contribute to turning the tide and preventing suicides. Through our collective efforts we can make a difference, and New York State is leading the way. **But we need All Hands on Deck!**

*If you are in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or contact the Crisis Text Line by texting "Got5" to 741-741.*

### *NYS Schools from page 5*

to a series of tragic deaths, the Town of Webb School District administration has committed to building on the strengths of the community in the form of upstream prevention. Sources of Strength – an evidence-based suicide prevention program that uses the power of peer leaders and trusted adults to spread messages of hope, help, and strength – is starting its fourth year in the district this fall. Just before school shut down this past spring, the Sources of Strength team from the University of Rochester sponsored a Point Break workshop for students. "Kids engaged in expressions of gratitude. They apologized to each other. When we were forced to close our building, we left with a common sense of connection. It was very impactful," said Principal Swick. The district also drew upon an abundance of nature to build a new outdoor playground and begin a tradition of day hikes to a local peak. "The hikes give kids an opportunity to open up, and you really see the adults

connecting with kids on a different level," said Principal Swick.

**North Syracuse:** Already having discussed school mental health promotion and suicide prevention efforts in a large metropolitan area and a small rural district, the OMH Suicide Prevention Office used grant dollars from its Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith (GLS) youth suicide prevention grant to support North Syracuse Central School District, a suburban district just outside of the city of Syracuse in Central New York. North Syracuse Central School District is made up of eleven schools serving more than 8,500 students. After two student suicides in the last months of 2019, administrators provided grief support to students, staff, and parents. In regrouping and debriefing after these initial efforts, there was a sense among school leaders that more could be done through professional consultation and training to integrate suicide prevention into school policy and procedure in a more systemic and ongoing way.

Working with OMH Suicide Prevention Office grant staff and community service provider Coordinated Care Services, Inc. (CCSI), the district disseminated SPCNY's school needs assessment, results of which were used to guide consultation and training. Based on the results of the needs assessment, district administration assured that all staff members were trained in suicide awareness, had written referral protocols for students identified at-risk, and that student support personnel attended Helping Students At-Risk (HSAR) workshops to prepare them to assess suicide risk and provide brief intervention. School-based mental health providers and community service leaders also attended the workshops to discuss coordination of referrals and communication protocols. Other experts volunteered to assist with standardizing suicide intervention procedures and documentation. District- and building-level administrators participated in planning and training as well. Planning continues as the district manages an uncertain fall semester. However, they are

strongly committed to mental health promotion and suicide prevention, particularly in the time of COVID-19 and all its associated uncertainty.

In my role as Director of the Suicide Prevention Office for New York State, I witness firsthand the need for suicide prevention across all ages. Our state's suicide prevention plan calls for developmentally informed programming across the lifespan. For youth, school-based prevention that creates pathways to care and increases access to treatment along with upstream approaches that increase student resiliency and healthy connections to others are crucial. From New York City, to North Syracuse, to the rural Town of Webb, we see how diverse schools and communities coming together to demonstrate hope, resilience and strength can make a difference, even when faced with painful loss.

*For more information on school-based training and technical assistance, please contact [pat.breux@omh.ny.gov](mailto:pat.breux@omh.ny.gov) at the Suicide Prevention Center of New York.*

### *Support Group from page 25*

with others with a shared experience. They know that if they are feeling suicidal, they always have someone they can reach out to who will understand their feelings without overreacting, which for many has not been the case when they have told family, friends or even professionals. The group seeks to increase participants' social connectedness, resilience, and coping skills and decrease suicide risk to help prevent future suicide attempts. A total of 152 individuals participated in the groups in Los Angeles and Orange County from 2011 to 2019, with many individuals participating in multiple cycles. Since some participants continue to experi-

ence suicidal thoughts and benefit from the support they find in the group, participants can choose to repeat the eight-week cycle if it is appropriate. In June 2020, SPC launched its first virtual SOSA group.

A 2018 study of SOSA has provided initial support of its efficacy in decreasing suicide risk among the participants (Hom, Davis, & Joiner, 2018). Since this publication, Didi Hirsch has continued to evaluate SOSA using pre- and post-measures to assess changes in participants' suicide risk. The results of the ongoing evaluation and focus groups with participants continue to support SOSA's efficacy in decreasing suicide risk among group participants. The results of the most recent evaluation show that group partici-

pants show a significant decrease in suicidal ideation as well as feelings of hopelessness, not belonging, and perceiving themselves as burdens on others. At the same time, they showed a significant increase in resiliency/coping skills and knowledge of safety planning.

The Didi Hirsch Suicide Prevention Center now has almost a decade of providing support group services to attempt survivors and has trained and supported many organizations across the country and the globe to implement support groups for attempt survivors in their communities. Through this bold and innovative work, SPC has shown that these groups are much needed, safe spaces for attempt survivors to meet with likeminded

individuals on their road to healing and recovery. This support group has demonstrated that bringing survivors together does not increase the risk of suicide behaviors; rather, doing so helps to decrease suicide risk factors and increase protective factors among attempt survivors - ultimately preventing future suicides.

*Sae Lee, PhD, is Division Director, Research and Evaluation, and Patricia Speelman, MA, LMFT, is Division Director, Suicide Prevention Center, at Didi Hirsch Mental Health Services. For more information about the support group, visit [didihirsch.org/services/suicide-prevention/](https://didihirsch.org/services/suicide-prevention/) or contact Patricia Speelman at [pspeelman@didihirsch.org](mailto:pspeelman@didihirsch.org).*

### How to Be There from page 12

in September and beyond, sharing these steps and raising awareness of the ways that people can stay socially connected while being physically distant can help empower us all to support each other through crisis and emotional distress. While #BeThe1To has been an active public health message since 2015, Vibrant Emotional Health has adapted the steps for COVID-19 and physical distancing.

#### The #BeThe1To Steps

**ASK:** Asking the question “Are you thinking about suicide?” communicates that you’re open to speaking about suicide in a non-judgmental and supportive way. Asking in this direct, unbiased manner can open the door for effective dialogue about their emotional pain and next steps. Research has shown that asking this question neither “puts the idea in someone’s head,” nor does it offend; people feeling suicidal are relieved that you care enough to ask the question. One can introduce the question after sharing your concern about how they have been feeling, and how the losses or stresses they have reported to you are affecting them. During times of physical distancing, in addition to being generally alert for potential risk in all loved ones, it is useful to pay special attention to people that already struggle or have struggled in the past with emotional distress. Make sure to reach out more frequently to talk and check in and don’t wait for them to come to you to ask for help or connection. Helping people stay connected can help to prevent people from thinking about or acting on thoughts of suicide.

**BE THERE:** For many, being alone

is not the same as feeling alone. Feeling alone is feeling as if no one cares about you or values you. How can you show a person who may be feeling “not cared about” that you care for them, if you can’t go see them? While being physically present may not be an option right now, there are still many other ways to be there for someone, including speaking with them on the phone/video phone, by text, through various online platforms. Make a list of people whom you would like to connect with regularly—including ones who support you (and can make you smile or laugh) as well as those whom you’d like to support--and try to reach out to one per day. The important things to keep in mind when maintaining social connection through distance are the regularity and quality of the connection. Establish the frequency in which the person would like you to check in with them, and then stick to that schedule. When talking on the phone or video calling with them, be present, non-judgmental, and listen. Remove distractions so that you can focus on your conversation. You can also plan to engage in fun activities together, either virtually or--if you both have been safely sheltered--for a time when you can be physically present together.

**KEEP THEM SAFE:** If you ask someone if they are thinking about suicide and they say yes, you can keep them safe and separate them from anything they are thinking of using to hurt themselves. Even while being physically distanced, take steps to put time and space between the person and items they may use to hurt themselves. You can use these questions/prompts to encourage the person to distance themselves from the means:

- If they have stated that they have the means for hurting or killing themselves, let them know how much you care about them and how important it is to you that they remain safe. Be honest with them about the gravity of your concern and talk with them directly about what they could do to make it harder for them to access those means in a crisis, when they might be more inclined to act impulsively. If the person has the means in hand while you are talking to them, ask if they could put it away from them while you talk. Call the **Lifeline** together.

- After you talk, ask the person to think about the overall safety of their environment. Is there anything else in their home, like firearms, that should be protected against to put more time and space between them and the potential means, even if those means of self-harm weren’t the person’s first intended plan? If others whom they trust live with or near them, ask if they can be included in helping to keep them safe.

**HELP THEM CONNECT:** Helping people connect with other services that can support them is still possible while staying physically distant. Developing a safety plan is an important step and can be done through the **My3 app**. The **Lifeline (800-273-8255)** is another great option during times of distance – trained counselors are available to call or chat 24 hours a day, seven days a week, and 365 days a year. Another option is to connect to a tele-mental health provider that can provide regular and consistent support from a mental health professional.

For people that may not be ready to connect with a counselor or mental health provider, the **Vibrant Safe Space website**

is home to resources and tools to provide you with choices of digital support in an emotionally safe environment. If others whom the person trusts are living with them, can safely visit, or be included in providing calls/texts/virtual screen meetings to check in and support them, it is important to generate a list of these people and contact them. Creating a circle of support—including both formal helping resources and friends/family-- will be vital to keep the two of you from dealing with this crisis alone.

**FOLLOW UP:** Never underestimate the value of showing up. Following up provides the person with a further feeling of connectedness. Similar to the principles of ‘be there’ during physical distancing, setting aside a time and date that you will follow up with a person in crisis can provide something to look forward to and sends the message that you care, and that they remain on your mind. Determine a time that works best for the two of you to check in regularly for a few days and/or weeks after. You can also send texts, notes, emails or whatever the person most readily responds to. When you are scheduled to connect--and eventually do connect--be sure to clear your calendar of all distractions for the time.

The National Suicide Prevention Lifeline and Vibrant Emotional Health are sharing the five #BeThe1To steps, as well as other resources and events, throughout September for Suicide Prevention Month. We welcome participation and collaboration from the public and other organizations in the mental health field. Message kits, graphics, resources, and events for September can be found at **bethe1to.com**. Find out more about the National Suicide Prevention Lifeline <https://suicidepreventionlifeline.org/>.

### COVID-19 Challenge from page 15

According to the **American Foundation for Suicide Prevention**, there were an estimated 1.4 million suicide attempts in the U.S. in 2018, which included 48,344 deaths — or an average of 132 per day.

Nearly 72,000 Americans, or 197 people a day, died from drug overdoses in 2019, an increase of 5% over 2018, and a new record, according to CDC **preliminary national data for 2019**.

The American Medical Association voiced its **concern** that states across the country were reporting an increase in opioid-related fatalities, particularly from fentanyl, the powerful synthetic opioid.

If you list the societal stressors that make our mental health and addiction crisis worse, COVID-19 exacerbates almost all of them: social isolation, economic instability, transportation disruption and challenges to getting support, anxiety related to social isolation, and societal unrest.

In addition to COVID-19, the opioid crisis, racial inequality in the U.S., disin-

vestment in communities, lack of access to care, and poverty, have taken a devastating toll on people of color across America.

Narcotic prosecutors are concerned that U.S. border closings disrupted illegal drug trafficking, leading to higher concentrations of synthetic fentanyl to make up for heroin “shortages,” potentially causing inconsistencies in what is sold and used on the streets. As a result, drug users are inclined to experiment with new drugs they are unfamiliar with, which could lead to greater overdoses and deaths.

**So many lives hang in the balance:** As Americans everywhere struggle with the enormous health, economic, and educational impact of responding to COVID-19, the fragile lives of people with opioid addictions and related behavioral health challenges have been made immeasurably worse.

There has never been a more urgent time for us to ensure our services are robust and our communities are not neglected. So many lives depend on all our services.

### LGBTQ from page 26

negative family attitudes and rejection after coming out can increase the risk of NSSI. Alienation from family can increase the risk of suicide. Schools can provide safe environments, promote equal rights, and reduce stigma. School-based interventions have been shown to help decrease suicidal ideation and suicide attempts. We know that non-discrimination clauses in things like healthcare have helped decrease the rates of suicide.

Helping youth to develop positive coping skills is vital. Positive coping skills have a negative relationship with suicide. Conversely, self-distraction, substance use, venting and self-blame were negative coping skills that had a positive relationship with suicide. Twenty-eight percent of LGBTQ youth have had therapy in the past year compared to 16% for the general population. The difference highlights the mental health needs of this cohort,

but therapy is a positive coping skill and should be promoted. Psychosocial interventions can help youth be more accepting of themselves, develop positive coping skills and ease any gender dysphoria that youth may be feeling. We can also help LGBTQ youth to develop resilience to deal with the impact of stress on their lives. We do this by validating the individuals and fostering supportive relationships.

Our society has come a long way in accepting the LGBTQ population but the crisis with our LGBTQ youth suggests there is still much to be done.

If you identify as an LGBTQ-IA youth and are in crisis, or know someone who is, call The Trevor Project: 1-866-488-7386.

If you are an adult in crisis, call the National Suicide Prevention Lifeline: 1-800-273-8255.

For a list of references please contact the author at: [Thomas.Grinley@dhhs.nh.gov](mailto:Thomas.Grinley@dhhs.nh.gov).

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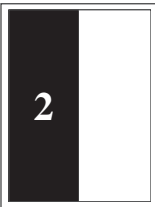
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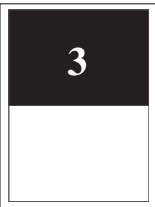
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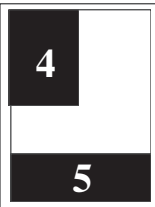
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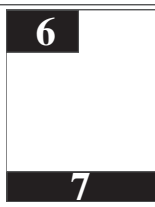
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