BEHAVIORAL HEALTH NEWS

YOUR TRUSTED SOURCE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER

WINTER 2025 EDUCATION, INFORMATION, ADVOCACY, AND COMMUNITY RESOURCES VOL. 12 NO. 3

Navigating the Impact of Suicide: From Prevention to Postvention

The Ripple Effect: Impact of Suicide on Family and Friends

By Glen P. Davis, MD
Chief Medical Officer
Institute for Community Living

The loss of a person to suicide touches friends, family, and other loved ones who must grapple with a host of emotions in the wake of tragic loss. The pain of suicide bereavement can ripple through personal relationships and affect the emotional health of the community of the individual who was lost. Levi-Belz and colleagues reviewed studies showing that every suicide affects an average of five family members and up to 135 community members. Understanding the impact on those left in the wake of suicide highlights the importance for all behavioral health professionals to develop sound policies and procedures to care for individuals who are at risk for suicide.

National Studies of Bereavement From Suicide

A large body of data has found that compared to other bereaved individuals and the general population, suicide-loss survivors are at greater risk for many severe mental health problems. In a large national survey in the United Kingdom, McDonnell and colleagues reported that 77% of survey participants reported a significant impact on their lives. High rates of mental health issues (37%) and physical health problems (22%) were reported, including anxiety, depression, and post-traumatic stress. Suicidal ideation was reported by 38%, and 8% attempted suicide following the loss of a loved one to suicide. Over one-third of the survey participants experienced adverse life events such as financial difficulties and the dissolution of family and other relationships and financial difficulties. A significant number of survey participants engaged in high-risk behaviors such as substance misuse and impulsive financial or sexual behaviors during and after their bereavement.

Suicide Bereavement and Complicated Grief

Research has also shown that bereavement from suicide loss can lead to complicated grief. Complicated grief is a prolonged and intense form of grief that can hinder the mourning process and impair an individual's functioning and quality of life. In a review titled Suicide Bereavement and Complicated Grief, Young et al. explored the unique challenges faced by individuals who have lost loved ones to suicide, emphasizing the higher risk of developing complicated grief (CG) compared to other types of bereavement. They noted that survivors can experience overwhelming

see Ripple Effect on page 8

Saving Lives: New York State's Comprehensive Approach to Suicide Prevention

By Ann M. Sullivan, MD
Commissioner
New York State Office of Mental Health

Ann M. Sullivan, MD

It is critical that across our state, we ensure that our local communities have the resources they need to identify and help individuals who are most at risk for suicide. Suicide is the second leading cause of death among individuals between the ages of 25 and 34 and the third leading cause of death for youth and young adults between the ages of 10 and 24. In New York, family and friends lose over 1,700 individuals each year to suicide. This is 1,700 too many.

These statistics are sobering and starkly lend to the understanding that every suicide takes an enormous toll on the families and friends of the individual and has a ripple effect, multiplying the collective toll on our communities.

While there is no single solution to preventing suicide, New York State is leading a multi-pronged effort with our Suicide Prevention Center of New York, which is housed at OMH and combines clinical and public health approaches in promoting, coordinating, and strategically advancing suicide prevention measures.

To support this important work, Governor Hochul invested a landmark $1 billion to strengthen New York's mental health care system in the 2024 State Budget and then $250 million in the 2025 budget. As a result, OMH has been able to expand specialized programs that are designed to reach New Yorkers who are either disconnected from or don't have access to traditional forms of care.

As part of this effort, we are expanding school-based mental health clinics statewide, bringing community-based care to the place where young people spend most of their time. With an investment of $19 million in this year's budget, any school in the state that wants to offer mental healthcare can partner with a licensed provider.

New York State is also tripling the number of Certified Community Behavioral Health Clinics, which provide comprehensive services and coordinate care across behavioral, physical health, and social service systems. We are using federal funding to spread the Zero Suicide model – a systemic approach toward integrating suicide prevention in the health care system – among 13 already established clinics, which will help address mental and behavioral health problems among youth.

We are also embracing and expanding programs that are focused on addressing higher suicide rates in specific groups, such as 'Life is Precious.' Established in 2008, this program is designed to strengthen protective factors to reduce and ultimately eliminate suicide attempts among Latina adolescents, who have historically higher rates than their peers. Life is Precious started as one center in the Bronx and has now grown to centers in Brooklyn, Queens, and Washington Heights, Manhattan. With funding from OMH, the program expanded in February 2023 to Poughkeepsie and Yonkers. New sites in Amsterdam and Hempstead will open later this year.

Along similar lines, the HAVEN-Connect program with George Washington University's Department of Psychological Brain Sciences is aimed at enhancing adaptive coping skills and preventing suicide among Black youth, with a focus on helping them build social and emotional connections within their churches. Originally funded by OMH in three churches located in Harlem, Albany, and Rochester, the program is now using an American Foundation for Suicide Prevention Focus Grant to expand into 12 additional sites statewide.

see Saving Lives on page 39

Compliance Management & Award-Winning Training All in One Place

Automate and streamline your compliance program with the top-quality content and support of Relias.

Learn More

RELIAS
relias.com

Newsweek America's Top Online Learning Providers 2023 statista

EdTech Breakthrough Award 2023

Brandon Hall Group Technology Excellence Award Gold 2022

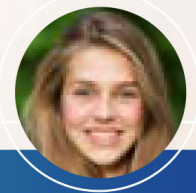
Top 100 Healthcare Technology Companies 2023

The Power to End Your Days On Time

Better For Your Patients. Better For Your Peace Of Mind.

Your new AI ally, **NextGen® Ambient Assist**, is built for behaviorial health. Improve clinical outcomes and end after-hours charting. Make time for more meaningful patient connections and better financial outcomes—and more time for you.

NextGen.com/Power-AI-BH



11:45

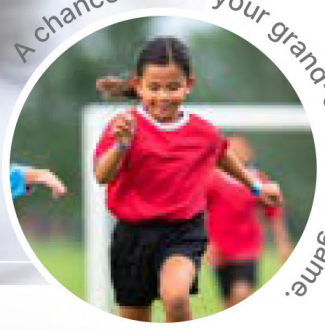
‹ Back Transcript

Nasir, Ali 07.11.2024

THERAPIST
"Are you refering to your parents divorce?"

PATIENT
"Yes as I cant keep it out of conversations with them and it's effecting my sleep."

UNDER 30 SECONDS
Automated SOAP Notes



Save up to Two Hours Daily on Documentation

nextgen® healthcare

Table of Contents

Navigating the Impact of Suicide: From Prevention to Postvention

In the News

Editorial Calendar

Spring 2025 Issue

Behavioral Health Services for Children and Families

Deadline: March 13, 2025

Summer 2025 Issue

Supporting Maternal Mental Health and Reducing Stigma

Deadline: June 12, 2025

Fall 2025 Issue

Understanding and Treating Anxiety and Depression

Deadline: September 10, 2025

Winter 2026 Issue

Behavioral Health Care Workforce Development and Innovation

Deadline: December 9, 2025

Contact us for information about advertising and article submissions

Stay Connected with BHN

Find over 1,500 behavioral health articles and 95 back issues at BehavioralHealthNews.org

Behavioral Health News Update

BehavioralHealthNews.org

Subscribe to receive the weekly BHN Update newsletters featuring even more behavioral health education, information, advocacy, and resources!

Mental Health News Education Board of Directors

Behavioral Health News Publication Sponsors

PLATINUM

GOLD

SILVER

SPONSORSHIP DETAILS	PLATINUM	GOLD	SILVER
Advertising and Article Space - With forward placement in four consecutive quarterly issues of BHN - View the current issue for examples	Full Page Advertisement	Half Page Advertisement	Quarter Page Advertisement
Leaderboard Advertising on BHN Website - Run sitewide on 1,500+ article posts with no paywall - Positioned below the top BHN logo	2 months	1 month	–
Top Banner Ad in the BHN Update Newsletter - View an example	3 Newsletters	2 Newsletters	1 Newsletter
Linked Logo Placement for 1 Year - On the BHN website - In four BHN quarterly issues - In all 52 BHN Update newsletters	1 Year	1 Year	1 Year

Contact us for information about becoming a Behavioral Health News sponsor

Behavioral Health News is a Quarterly Online Publication of Mental Health News Education, Inc., a 501(c)(3) Nonprofit Organization

All inquiries regarding advertising, sponsorships, and submitting an article should be directed to:

Ira Minot, LMSW, Founder, Mental Health News Education, and Publisher, BehavioralHealthNews.org

Leveraging Digital Tools: Innovative Technology for Suicide Prevention and Support in Healthcare

By InvisALERT Solutions

Suicide remains one of the leading causes of death worldwide, with over 700,000 people taking their own lives each year (*World Health Organization, 2021*). Beyond the immense emotional toll it inflicts on families and friends, suicide places a heavy burden on healthcare systems. Over recent years, technological innovations have provided new opportunities for suicide prevention, particularly within healthcare environments such as hospitals and mental health inpatient and residential facilities.

These digital and other advanced technologies help staff manage and monitor at-risk individuals with real-time crisis interventions, reminders, and alerts that improve overall patient safety. The impact of new technologies is shaping suicide prevention efforts in healthcare settings. These technologies are evaluated, with a particular focus on patient care and safety.

Digital Screening Tools for Suicide Risk

One of the most critical applications in healthcare settings is the use of digital screening tools to assess suicide risk. Tools are increasingly being employed to determine the assessment process. These evidence-based tools help healthcare staff quickly identify individuals who may be at elevated risk of suicide, providing timely intervention and protection.

Digital versions of these tools integrate with Electronic Health Records (EHR), allowing for immediate access to the data and reducing the likelihood of errors or delays in risk assessments and remedies. By automating suicide risk screenings, healthcare facilities can ensure objectivity and consistency in assessing patients for signs of suicidal ideation, making early identification more systematic and less dependent on subjective assessments.

Additionally, AI-driven tools are beginning to be used for more dynamic risk assessment. For instance, machine learning algorithms can analyze patient data—such as recent changes in mood, behavior, or medical history—along with responses to screening questionnaires to predict potential suicidal behaviors. These systems can flag patients for further evaluation by staff members, significantly improving the accuracy and timeliness of suicide risk assessments and interventions.

Patient Monitoring through Wearable Devices

Wearable technology has transformed patient monitoring in healthcare, providing a new and effective way to access emotional and physiological signs of distress in real-time. Devices such as specialized wearables can monitor various indicators that may signal emotional, mental, or physical health crises.

In inpatient mental health settings, these devices are used to ensure consistent monitoring of patients for signs of anxiety, depression, and other mental health conditions linked to suicidal ideation. By providing staff with proximity-required observations, real-time reminders, and alerts, staff members are prompted to observe and intervene quickly—before suicidal thoughts or actions escalate. This proactive approach not only helps in monitoring high-risk individuals but also reduces the reliance on manual checks, making the process more consistent and effective.

As a result, healthcare teams are better equipped to intervene earlier, reducing the chances of a patient reaching a crisis point. With such innovations, the risk of suicide can be minimized through timely, informed action that prioritizes patient safety without compromising care.

Real-Time Data for Patient Management

Healthcare facilities are increasingly turning to data-driven tools to improve patient outcomes and prevent suicide. Real-time data collection and analysis enables staff members to monitor a variety of factors that may indicate suicide risk, such as changes in behavior.

By utilizing data analysis, professionals can identify subtle indicators of distress or deteriorating mental health that may not be immediately visible through direct observation. For example, aggregated data from patient evaluations and clinical assessments can highlight recurring patterns in mood changes, medication adherence, or even social interactions that could point to an increased risk of suicide. With this information, healthcare teams can proactively act, adjusting treatment plans, increasing observation intervals, and providing additional support before a crisis occurs.

This data-driven approach enables healthcare teams to make more informed decisions, enhancing patient care and safety. By shifting from traditional reactive strategies to a proactive, collaborative model, healthcare facilities can more effectively reduce the risk of suicide, ensuring patients receive timely support and interventions when they need it most.

Digital Suicide Prevention Tools for Inpatient Settings

Several digital tools are specifically designed for use in hospitals, mental health inpatient, and residential facilities where patients at risk of suicide may require constant monitoring and specialized care.

In inpatient settings, it is critical that technology is integrated into the care process in a way that supports, rather than replaces, human interaction. Studies have demonstrated that integrating such digital tools into a broader care plan reduces suicide risk. A study conducted by (*Ripperger-Suhler et al., 2018*) found that combining traditional therapy with digital mental health tools significantly improved the well-being of patients at risk for suicide in clinical settings. Digital tools should act as extensions of existing mental health support networks, enhancing rather than substituting direct clinical care.

For example, in some facilities, healthcare staff members use technology to supplement face-to-face interactions and enhance the care process. Tools allow staff to monitor patients' progress and receive real-time updates on their well-being. Technology enables more frequent check-ins and facilitates ongoing communication between staff and patients, ensuring that patients feel supported even when not in direct contact with a physician. By integrating these technologies into a patient's care plan, staff can provide more personalized, responsive interventions, ultimately helping to prevent suicide and improve patient outcomes.

The Importance of Patient-Centered Care in Digital Monitoring

Despite the effectiveness of digital tools in suicide prevention, it is essential that these technologies are integrated in a way that respects patients. For example, while certain technologies can alert healthcare providers to potential risks, they should be implemented in a manner that minimizes patient distress and protects their privacy. Healthcare professionals must carefully balance safety measures with the need to uphold patients' autonomy and confidentiality, especially in sensitive mental health environments.

In hospitals and facilities, patient-centered care should be at the forefront of any technological innovation. This means that while technology is used to monitor and assess patients' conditions, it should also enable staff to engage meaningfully with patients. Communication and trust-building remain essential components of suicide prevention. Technology should not replace the human connection necessary for a therapeutic relationship but should enhance the ability of healthcare to provide the right care at the right time.

Enhancing Patient Safety in Inpatient Mental Health Facilities

In inpatient settings, one of the most essential elements of suicide prevention is constant patient observation. However, traditional 1:1 observation protocol, while necessary, can sometimes lead to patient distress or staff burnout. Patients under constant surveillance may feel stigmatized or dehumanized, while staff members may struggle with the emotional and physical demands of maintaining high levels of constant observation around the clock.

This is where tools like ObservSMART play a crucial role. ObservSMART is a patient safety and compliance tool specifically designed to authenticate the monitoring of patients through proven proximity-required technology. Since patient acuity can vary, ObservSMART provides staff with needs-based, patient-specific monitoring capabilities. Since 1:1 monitoring can be costly, labor intensive, and can contribute to staff burnout, ObservSMART provides varied patient intervals to fit each patient's needs, thus reducing the need to default to a constant observation scenario *(ObservSMART, 2024)*. In cases where there is no other option but to prescribe a 1:1, ObservSMART provides teams with the technology to assist and ensure the 1:1 observation protocols are always in effect, thus reducing the likelihood of sentinel events missed warning signs and ensuring that patients receive the best of care.

The use of ObservSMART reduces the risk of harmful side effects associated with traditional 1:1 observation practice. The staff-to-patient proximity-required 1:1 device, proactive real-time alerts, clear documentation, and improved staff communication, minimizes unnecessary interventions, which can be distressing for patients. ObservSMART helps staff to stay focused on providing consistent, compassionate care. The technology ensures patients are observed on time and in a manner that is respectful and aligned with an organization's safety goals.

Ultimately, ObservSMART is an example of how technology in healthcare can be used to strike a balance between effective suicide prevention and compassionate, patient-centered care.

Shaping Suicide Prevention with Technology

As suicide rates continue to rise, healthcare facilities are increasingly turning to digital innovations to enhance their ability to prevent suicide and support at-risk individuals. Innovations such as digital screening tools, wearable devices, and real-time data systems are allowing healthcare staff to monitor patients more closely and intervene proactively.

Additionally, patient safety technology tools are enhancing the ability to provide safe, non-intrusive observation for high-risk individuals, ensuring that patients receive the care they need without compromising their well-being. By utilizing these technologies, healthcare systems are better equipped to address the current suicide crisis with greater precision, compassion, and effectiveness.

For media inquiries, contact cshows@invisalertsolutions.com or visit our website at www.ObservSMART.com.

References

ObservSMART. (2024). *ObservSMART 1:1.*

Ripperger-Suhler, J. L., Green, A. M., & Morse, A. (2018). *Teletherapy: An emerging tool in suicide prevention.* Journal of Telemedicine and Telecare, 24(7), 485-490.

World Health Organization (WHO). (2021). *Suicide prevention.*

ObservSMART

INNOVATIVE COMPLIANCE TECHNOLOGY

Transforming healthcare settings with proximity-required safety monitoring, 1:1 assurance and proactive alert interventions for at risk patients

Observation | Compliance | Safety

Ripple Effect from page 1

feelings of guilt, confusion, rejection, shame, anger, and trauma. Survivors can face societal stigma, inhibiting their ability to openly discuss their loss, which can impede healing.

Mental Health Effects of Suicide Bereavement

In *The Relationship Between Guilt, Depression, Prolonged Grief, and Posttraumatic Stress Symptoms After Suicide Bereavement*, Wagner et al. investigated how guilt interacts with symptoms of depression, prolonged grief, and posttraumatic anxiety in people who have experienced suicide bereavement. Their study used cross-sectional data from 154 participants in Germany, examining the moderating role of guilt in relation to the time since the loss. Key findings were that guilt related to bereavement from suicide loss significantly correlated with depression, prolonged grief, and posttraumatic anxiety.

Physical Effects From Suicide Bereavement

There is a large body of literature showing that relative to other bereaved individuals and the general population, suicide-loss survivors are at increased risk for medical health problems. In a study conducted in Ireland, Spillane et al. explored the physical effects of suicide bereavement on family members using a mixed-methods approach. Participants reported physical symptoms such as nausea, chest pain, and insomnia, while nearly one-quarter endorsed symptoms of depression, 18% endorsed anxiety, and 27% posttraumatic stress. They noted that psychological stress can impact the immune system, contributing to gastrointestinal symptoms, headaches, and sometimes heart disease.

Family Dynamics

Other studies have focused on family dynamics in the context of suicide bereavement. Creuze and colleagues investigated the impact of suicide bereavement within families with a focus on emotional, relational, and communication dynamics following the loss of a family member to suicide. Sixteen family members who lost a close relative to suicide were interviewed. These interviews highlighted the family trauma associated with the loss. Families reported logistical and financial challenges, stress from police investigations around the death of their loved one, and societal stigma. The study indicated that fear of further suicides within the family and difficulty forming new relationships outside the family were prevalent. Pre-existing family dynamics – both positive and negative – were often amplified.

In *Experiences of Parental Suicide-Bereavement: A Longitudinal Qualitative Analysis Over Two Years*, Entilli and colleagues conducted interviews over a two-year period of parents who lost a child to suicide. They found that parents often shifted their focus from intense anger to blame and more reflecting reasoning. Some parents moved toward acceptance, while others struggled with depression and rumination over the loss. Some families exhibited maladaptive coping, such as avoidance and excessive working, while some engaged in more adaptive strategies, such as self-

Glen P. Davis, MD

care and routine memorialization of their child. While some continued to face challenges in making sense of the loss in their recovery, some began to find meaning and purpose in the loss of their child, showing resilience and personal growth. Patterns of gender differences were noted, with fathers leaning toward restoration-oriented activity (activity-oriented) while mothers exhibited a loss-oriented approach and expressed grief more openly. Some parents in this study were able to reframe their experience as an opportunity for growth, adopting positive lifestyle changes, while others highlighted the variable trajectory of grief.

Adolescents Affected by Suicide Loss

Qualitative studies have shown that a suicide event can be particularly distressing for adolescent peers of the affected individual. Andriessen and colleagues investigated the impact of suicide on adolescents through interviews, exploring how suicide deaths shaped adolescent experiences. They found that bereaved adolescents often experience profound loneliness compared to peers who have not experienced the loss of a friend to suicide. Bereaved adolescents interviewed in the study reported engaging in risky behaviors while their parents struggled to provide sufficient emotional support. The group noted that some adolescents reported personal growth stemming from their process of bereavement, albeit with emotional costs.

Del Carpio and colleagues did a systematic review studying the impact of suicide bereavement in adolescents aged 12 – 18, studying key differences between bereavement by suicide compared to other types of bereavement. They noted that adolescents experiencing suicide bereavement have a higher risk of suicide mortality themselves, especially following the suicide of a parent. They found that maternal suicides presented a particularly elevated risk relative to parental suicides or non-suicide parental deaths. Earlier experiences of loss and shorter timeframes since bereavement were identified as significant factors elevating risk among adolescents.

Older Adults Affected by Suicide Loss

Other suicidologists have studied bereavement by the suicide of older adults later in life. Hafford-Letchfield et al. reported that older individuals bereaved by suicide can also experience intense guilt, shame, and stigma related to traumatic loss. Suicide bereavement among older adults differs from that of younger individuals in that they are more likely to reflect on their own aging and mortality in the context of the loss, expressing concerns about future dependencies and social isolation. Their study highlighted the need for targeted support for this group, including psychosocial interventions and training for professionals to improve their ability to address the unique needs of older bereaved individuals. They also noted that peer support networks play a significant role in the healing of older adults bereaved by suicide.

Spirituality and Religion as a Coping Mechanism

Čepulienė and Skruibis explored the role of spirituality and religion in the process of suicide bereavement. They offered that spirituality serves as an important resource during grief, contributing to the "meaning making" and providing emotional strength during suicide bereavement. Tools such as personal rituals, religious practices, and spiritual beliefs can help individuals process their loss and maintain a connection with the deceased. However, they note that spirituality can also complicate the grieving process, leading to feelings of guilt, stigmatization, or spiritual crisis, raising existential questions and inviting societal judgments around suicide. They emphasize the importance of a tailored approach from religious practitioners who are assisting the bereaved, pointing out the dual role of spirituality, which can offer solace while potentially introducing complications in the bereavement process.

Post-Vention inSuicide Bereavement

There is a significant body of literature on the provision of "post-vention" support for those grieving from a loss to suicide. In a national, cross-sectional survey of young adults in the United Kingdom, Pitman and colleagues interviewed young adults who experienced sudden loss of close contact to suicide. They found that 25% of suicide-bereaved individuals received no formal or informal support, highlighting a gap in care. The stigma surrounding suicide contributed to reduced support, both regarding seeking and receiving help. When bereaved individuals relied on formal support through health services, they often faced delays in accessing help. They suggested the development of national outreach systems to provide immediate, tailored support for individuals bereaved by suicide.

Conclusion

The ripple effect of suicide-affected individuals and their families and friends is a powerful reminder of the imperative for mental health professionals to develop clear plans for how to manage suicide risk in their work with clients – whether they are providing services to individuals in solo practice, as part of a group practice or a larger hospital system or behavioral health agency. All mental health professionals must become facile and comfortable asking questions about suicide risk, recognizing warning size, and connecting those at risk with the appropriate level of mental health services to reduce suicide incidence. And for those who have lost a family member or friend to suicide, sharing their stories can foster a community where seeking help is de-stigmatized, normalized, and welcomed.

The aftermath of suicide touches the lives of everyone who knew the individual affected by the event, far beyond the nuclear family of the deceased. There is no one-size-fits-all in the journey to healing. In addressing the ripple effect of suicide loss, mental health professionals can offer both individual and systems-level support to survivors.

Glen P. Davis, MD, is Chief Medical Officer at Institute for Community Living.

References

Andriessen K, Krysinska K, Rickwood D, Pirkis J. "It Changes Your Orbit": The Impact of Suicide and Traumatic Death on Adolescents as Experienced by Adolescents and Parents. Int J Environ Res Public Health. 2020 Dec 14;17(24):9356.

Čepulienė, A.A.; Skruibis, P. The Role of Spirituality during Suicide Bereavement: A Qualitative Study. Int. J. Environ. Res. Public Health 2022, 19, 8740.

Cerel, J.; Brown, M.M.; Maple, M.; Singleton, M.; Van de Venne, J.; Moore, M.; Flaherty, C. How many people are exposed to suicide? Not six. Suicide Life-Threat. Behav. 2019, 49, 529–534.

Creuzé, C.; Lestienne, L.; Vieux, M.; Chalancon, B.; Poulet, E.; Leaune, E. Lived Experiences of Suicide Bereavement within Families: A Qualitative Study. Int. J. Environ. Res. Public Health 2022, 19, 13070.

Del Carpio L, Paul S, Paterson A, Rasmussen S. A systematic review of controlled studies of suicidal and self-harming behaviours in adolescents following bereavement by suicide. PLoS One. 2021 Jul 9;16(7):e0254203.

Entilli L, Ross V, De Leo D, Cipolletta S, Kõlves K. Experiences of Parental Suicide-Bereavement: A Longitudinal Qualitative Analysis Over Two Years. Int J Environ Res Public Health. 2021 Jan 11;18(2):564.

Hafford-Letchfield, T.; Hanna, J.; Grant, E.; Ryder-Davies, L.; Cogan, N.; Goodman, J.; Rasmussen, S.; Martin, S. "It's a Living Experience": Bereavement by Suicide in Later Life. Int. J. Environ. Res. Public Health 2022, 19, 7217.

Levi-Belz, Y.; Krysinska, K.; Andriessen, K. What Do We Know about Suicide Bereavement, and What We Can Do to Help Suicide-Loss Survivors? Int. J. Environ. Res. Public Health 2023, 20, 5577.

McDonnell, S., Flynn, S., Shaw, J., Smith, S., McGale, B., & Hunt, I. M. (2022). Suicide bereavement in the UK: Descriptive findings from a national survey. Suicide and Life-Threatening Behavior, 52, 887–897.

Pitman AL, Rantell K, Moran P, et al. Support received after bereavement by suicide and other sudden deaths: a cross-sectional UK study of 3432 young bereaved adults. BMJ Open 2017;7:e014487.

Spillane A, Matvienko-Sikar K, Larkin C, et al. What are the physical and psychological health effects of suicide bereavement on family members? An observational and

see Ripple Effect on page 34

OnTrackNY at ICL's East New York Health HUB

Institute for Community Living (ICL)'s OnTrackNY offers comprehensive, personalized support to teens and young adults (16-30 years old) who are impacted by unexpected changes in their thinking and perceptions.

ICL's OnTrack NY is:

- *Recovery-Oriented*
- *Collaborative*
- *Equitable & Inclusive*
- *Person-Centered*

LOCATED AT ICL'S EAST NEW YORK HEALTH HUB, OUR PERSON-CENTERED MODEL OF CARE PROVIDES COMPREHENSIVE SUPPORT, INCLUDING THERAPY, HELP WITH SCHOOL AND WORK, PEER SUPPORT, CONNECTION TO COMMUNITY RESOURCES, SUPPORT FOR PHYSICAL HEALTH, FAMILY SERVICES AND/OR MEDICATION.

NYSPA Report: New Federal Policy in Support of Suicide Prevention

By Rachel A. Fernbach, Esq.
Executive Director and General Counsel
New York State Psychiatric Association

Earlier this year, the Biden Administration launched a new national strategy on Suicide Prevention. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA):

> In the United States, someone dies by suicide every 11 minutes; the rates of suicidal behaviors have risen over the past decade; and disparities in suicide rates among certain populations are growing… There also is concern about suicide trends amid the ongoing mental health and overdose crises and on the heels of the COVID-19 pandemic, in which many people experienced loss, social isolation, behavioral health problems, and inequities in health care resources, education, housing, and other suicide risk factors.[1]

SAMHSA's action plan calls on all individuals to:

- ***Care*** about suicide prevention through a thoughtful strategy that blends prevention, intervention, treatment, and postvention support.

- ***Connect*** our prevention efforts to community and culture as key protective factors for health and wellbeing.

- ***Collaborate*** with public and private sector partners, people with suicide-centered lived experience, and populations disproportionately affected by suicide to achieve meaningful, equitable, and measurable advancement in suicide prevention.[2]

This federal strategy includes improving collection and reporting on data collected through 988, the National Suicide Prevention Lifeline, as well as assisting states in providing support for populations disproportionately impacted by suicide and partnering with other federal agencies.

The U.S. Department of Health and Human Services has also prioritized suicide prevention in the administration of federal health care programs. According to data issued by the federal Centers for Disease Control and Prevention, the suicide rate among those age 65 and older, who make up a majority of the Medicare population, increased 4.5% from 2021 to 2022.[3] This is a vulnerable population that requires enhanced support and intervention. On November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) issued its final Medicare physician fee schedule (PFS) rule finalizing changes to Medicare physician payments and other Medicare Part B policies, effective January 1, 2025.[4]

This year, the Medicare PFS final rule includes coverage for a variety of new services focused on enhancing access to behavioral health services. These new services are intended to address patients in crisis, including those with suicidal ideation or those at risk of dying by suicide or overdose. Newly covered services include safety planning intervention, post-discharge telephone follow-up contact, and digital mental health treatment.

Safety Planning Interventions

The new Safety Planning Intervention service code is intended "to develop a personalized list of coping and response

see Federal Policy on page 28

$1,000 - $3,000 SIGN-ON BONUS*

WE'RE HIRING!

NYC & LONG ISLAND

Become a part of the WellLife Network Team and provide hope and inspiration to assist individuals in attaining their life goals of health, recovery, wellness, and independence.

TO APPLY IN ADVANCE, SCAN QR CODE

*On designated openings

EMAIL TODAY:

HumanResources@WellLifeNetwork.org

WellLife Network is an equal opportunity employer.

COMPETITIVE BENEFITS PACKAGE

- 401(k) matching
- Medical, Vision & Dental Insurance
- Disability Insurance
- Employee Assistance Program (EAP)
- Flexible Spending Account/Dependent Care Account
- Life insurance (Term and Whole)
- Paid Time Off
- Referral Bonus Program
- Tuition Assistance
- Gym Pass
- WLN is a Qualifying Employer for the Public Service Loan Forgiveness (PSLF) Program
- Leadership Training
- Mentorship Opportunities
- Career Development Extensive Training programs
- Internship Opportunities

WellLife Network

GreatNonprofits 2023 Top-Rated Nonprofit

Platinum Transparency 2023 Candid.

Forbes 2022 America's Best-In-State Employers New York

Top Long Island Work Places 2020 Newsday

Dutchess County's Stabilization Center Among New York's First Licensed Supportive Crisis Stabilization Centers

By People USA

Dutchess County's first-of-its-kind Stabilization Center, a partnership between the Dutchess County Department of Mental Health (DCDMH) and People USA, recently became one of the first Supportive Crisis Stabilization Centers licensed by the New York State Office of Mental Health (NYS OMH) and the State's Office of Addiction Services and Supports (OASAS), further solidifying the facility as a model to be emulated and duplicated throughout the state and beyond.

Opened in March 2017 as the only such facility in New York, Dutchess County's Stabilization Center is a 24/7, non-medical, voluntary, walk-in center for individuals experiencing crisis resulting from mental health or substance use issues. Located at 230 North Road in Poughkeepsie, the Stabilization Center provides law enforcement and Dutchess County's 24/7 Mobile Crisis Intervention Team the ability to divert individuals with behavioral health or substance use issues so they can receive immediate assistance and services in order to de-escalate crisis and plan for ongoing services upon departing the center.

Since its opening, the Stabilization Center has operated as a public-private collaboration, with DCDMH working with community partners to bring about positive results for its guests. Highlighting the success of that Dutchess County model, NYS OMH and OASAS have issued the new license to People USA to operate the Stabilization Center.

From left: Himali Pandya, Chief Strategy Officer, People USA; County Executive Sue Serino; Patrick Wildes, Assistant Secretary to the Governor for Human Services and Mental Hygiene; Jean-Marie Niebuhr, Dutchess County Mental Health Commissioner; Steve Miccio, Chief Executive Officer, People USA; Harvey Rosenthal, CEO, The Alliance for Rights and Recovery; Luke Sikinyi, Director of Public Policy, The Alliance for Rights and Recovery; Kimberly Wing, Chief Operating Officer, People USA; and Ben Groff, Chief Human Resources Officer, People USA, toured Dutchess County's Stabilization Center earlier this week.

County Executive Sue Serino said, "For years, Dutchess County's Stabilization Center has made a marked impact on the lives of thousands of residents of all ages, leading to positive outcomes for its guests. We have always known the value of our Stabilization Center, and we are thrilled New York State similarly values its life-saving influence. As a licensed facility, our Stabilization Center is not only the cornerstone of Dutchess County's mental health and addiction services programs, but it's a shining example for other communities – throughout New York and the nation – to replicate and realize similar success. Dutchess County is so proud of its partnership with People USA, which has culminated in this historic achievement."

In 2023, the Stabilization Center served more than 3,000 guests, including nearly 800 under the age of 18, helping divert them from hospital emergency departments or incarceration.

Steve Miccio, People USA's Chief Executive Officer, said, "For seven years, the Stabilization Center has been a beacon of hope for so many in our community, often serving as their first step along their journey

see Stabilization Center on page 38

Suicide Prevention and Response: Fostering Trust and Safety in Vulnerable Communities

By James Chavez, LCSW, and Dani York, LCAT, RDT
Services for the UnderServed (S:US)

Suicide carries grief and mourning and encompasses assumptions, histories, and fantasies. It holds the dialectic of abbreviated narratives and hope-filled storylines for those who survive. 2022 U.S. data from the American Foundation for Suicide Prevention (AFSP) indicates that 1.6 million adults made a suicide attempt and 49,476 adults died by suicide. According to the data, many who survived an attempt did not make further attempts, indicating that prevention efforts lead to positive outcomes. In fact, 94% of adults surveyed believe suicide may be prevented.[1] Given the breadth of loss that those impacted by suicide experience, a societal hopefulness around prevention lays the groundwork for treatment services that offer just that. Providing ease of access to care while destigmatizing symptoms through empathic collaboration can cultivate safety for individuals who experience suicidal ideations, as well as for their support networks.

Services for the UnderServed (S:US) is one of the largest community-based health and human services organizations in New York State that works intentionally and daily to right societal imbalances by providing comprehensive and culturally responsive services. Prevention is at the core of the agency's mission. Goals within preventative services aim to decrease suicidal thoughts and alleviate feelings through skills building, to develop comfortability in disclosing thoughts, and to begin shifting narratives through trauma-informed care. Efficacy is highly dependent upon the approach. S:US' Certified Community Behavioral Health Clinics (CCBHCs) utilize a multidisciplinary team approach, providing treatment and crisis interventions on-site, in the community, and through telehealth. CCBHCs employ screeners and assessments to determine levels of risk for an individual who experiences suicidal ideations or participates in treatment following an attempt. When a person presents at-risk for suicide, scoring high risk when screened with the Columbia Suicide Severity Scale (C-SSRS)[2] or is at risk for suicide by overdose, S:US utilizes the Stanely-Brown Safety Planning Intervention (SPI)[3] to identify warning signs, establish coping skills, and name people and community supports to assist during a crisis. SPI encourages exploration of the contributing narrative to ideation or attempt, seeking to understand the complexity of each individual's story. Weekly multidisciplinary meetings carve out space for discussing complex cases, ensuring a multi-framed lens to act in service of safety and wellness. Case conferences give value to varied perspectives through which an individual in crisis and networks of support determine immediate next steps while fostering hope and connection. Wraparound services respond to the stressors that often trigger suicidal ideation, such as acute stress, isolation, food and housing insecurity, and other social determinants of health.

Many at risk of suicide do not have family or a community and may not seek help in times of crisis due to stigmatization, fear of hospitalization, or hopelessness. S:US identifies support systems as not only family members and friends but also social service providers, community and faith-based organizations, and neighbors. Understanding the makeup of an individual's support network helps identify untapped resources in suicide prevention. Given that a contributing factor to increased risk for suicide is social isolation, S:US' efforts rely on the network of care in our Recovery and Treatment programs[4] to provide wraparound services to people at risk of suicide. This network can serve as a surrogate support network by connecting individuals with our array of programs geared toward emotional wellness and community integration. Engagement within this network is a critical component of suicide prevention. For example, within CCBHCs, engagement begins with a referral to treatment, identifying emergency contacts and other potential support pathways, then continues through intake such that the moment an individual connects with CCBHCs, staff, and the individual have access to those in a position to assist during times of risk.

Several programs rely on Peer Specialists embedded within. Utilizing their unique lens and approach as a person with lived experience and recognizing the stigma associated with mental illness and substance use that often leads to social isolation, our Peers work with individuals through a Motivational Interviewing lens to invite family and friends into focused recovery efforts. Wraparound by Peers and others decreases the burden of care for family and friends who may simultaneously experience the uncertainty, shame, or fear that creates a barrier to help; these efforts reduce overwhelm as an alternate means of engaging others in suicide prevention. Moreover, Peers conduct outreach for wellness, distribute resources, escort to appointments, and guide individuals toward longer-term treatment as prevention. Additionally, the S:US Brooklyn Clubhouse aims to help individuals integrate into their communities and offers access to the necessary tools to obtain and maintain employment, cultivate meaningful relationships, participate in recreational opportunities for socializing, overcome stigma, and pursue wellness in a supportive and nurturing environment. S:US Care Coordination provides person-centered, community-based, and telehealth services that combine case management, harm reduction, and collaboration with providers; they connect individuals with resources to prevent hospitalization and improve functioning by enhancing community support.

To support individuals who have suffered from suicidal thoughts and feelings or have made an attempt is to also support providers. To best support staff who may also be impacted by suicide/crisis, training plans offer learning on best practices, creative efforts to maneuver complex cases, fortify confidence and competence in crisis response, and enhance empathic response. Internally developed training offers approaches that highlight trauma-informed, person-centered care, understanding that an individual experiences psychic pain during a suicidal crisis. Training not only teaches interventions but engagement strategies that foster exploration of the mass of emotions present in individuals in crisis. Learning how to build upon the larger contextual narratives that contribute to suicide risk is fundamental in prevention, highlighting the nuanced ways in which suicidal thoughts, feelings, and actions emerge and are expressed. Feeling seen and heard in vulnerability and witnessed in the strength that underlies vulnerable moments can be a developed skill. Training efforts that extend beyond the reach of staff encourage nonclinical staff, family members, and friends to learn more about

see Trust and Safety on page 29

A Unique and Insidious Grief: Losing a Loved One to Suicide

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

Deaths by suicide are unquestionably tragic by any measure, but considerably more so when considered in the context of their impact on surviving family members. Most public health initiatives have logically targeted individuals at risk of suicide and promoted prevention efforts accordingly; fewer have addressed the complexities of decedent-survivor relationships and variables that influence survivors' grief responses. An emerging body of research aims to illuminate factors that influence survivors' responses and predispose them to prolonged grief, the onset or exacerbation of existing mental health conditions, and risk of suicide.

Suicide is an exceptionally complex phenomenon and the subject of extensive analysis by clinicians, social scientists, philosophers, and theologians. The 19th Century sociologist Émile Durkheim's seminal work on the subject was among the first to situate suicide in a social context whose causes and effects are not limited to individual temperament or psychopathology (Durkheim, 1897). Durkheim's leading thesis that social connectedness serves as a protective factor for those who would otherwise be at risk of suicide is axiomatic when viewed in hindsight, but it opened avenues for subsequent investigations into the intricacies of human relations and how they might affect, and be affected by, the act of suicide. Research findings suggest innumerable factors influence the trajectory of a survivor's response to a completed suicide that include the role of the decedent (e.g., father, mother, child, sibling, etc.) relative to the survivor; age and gender of the decedent and survivor; prior familial history of mental illness or emotional disturbance; race, ethnicity, culture, and nation of origin; and genetics, among many others. Some investigations have also explored the manner in which stigma that often attends the act of suicide might complicate a survivor's coping mechanisms and undermine the recovery processes.

Researchers in South Korea examined risk factors among individuals who lost family members to suicide. Their investigation explored differential risks according to family role and factors that distinguish suicide survivors' responses from those whose family members died by other means. This study found women whose husbands had completed suicide were at greatest risk of all family members (Jang et al., 2022). Men who lost their wives to suicide were also at significant, albeit slightly lesser, risk, as were mothers who lost children to suicide. The risk of completed suicide was lowest among sibling and child survivors. The foregoing risks also varied according to several factors. For instance, gender was implicated in the risk trajectory, as mothers who lost daughters to suicide were at greater risk than mothers who lost sons. A similar trend was observed among siblings insofar as women who lost sisters to suicide were at greater risk than women whose lost brothers to suicide. This investigation also found suicide survivors were at threefold greater risk than those who lost family members to traffic accidents, a result that suggests suicide produces especially complex and severe grief responses among surviving family members (Jang et al., 2022). It should be noted, however, that conclusions drawn from this study must be interpreted in the context of the environment in which it was conducted. Familial dynamics vary greatly across nations and cultures, and factors specific to South Korean society might not be as present or as influential in other regions.

Another investigation addressed risk factors specific to child survivors of suicide, an especially critical endeavor in consideration of the risks unique to children and adolescents as they navigate other developmental challenges. Pfeffer et al. (1997) examined various dimensions of children's responses to the loss of a parent or sibling to suicide and explored an array of factors that might influence both their risk of suicide and the trajectory of their recovery process. These authors found child survivors were at elevated risk of depression, anxiety, posttraumatic stress, and social maladjustment, but this risk was not universally present among study participants. For instance, when surviving (caretaker) parents of child survivors exhibited profound grief, distress, or other indications of psychiatric illness in the wake of the suicide, their children were similarly affected. The authors hypothesized these parents were less emotionally available to their children or ill-equipped to aid them in modulating their grief responses. This investigation also addressed potentially confounding variables applicable to studies of this type that underscore the intricate and multifaceted nature of suicide and its impact on family members. For example, first-degree relatives of decedents with documented histories of mental illness or suicidality are more likely to exhibit similar conditions or predispositions (Pfeffer et al., 1994). Thus, children whose parents experienced mental illness prior to suicide might be more vulnerable to psychopathology and at risk of its adverse effects irrespective of their parents' suicide. Moreover, an extensive body of literature suggests both environmental and genetic factors are implicated in mental illness and suicidality. One study of suicidality among monozygotic and dizygotic twins revealed a significantly higher correlation among the former (i.e., identical) twin pairs (Coon et al., 2020), and another found familial "dysfunction" (i.e., disorganization, divorce and estrangement, interfamily violence, etc.) was more common among families of suicide victims (Jordan, 2001). The foregoing investigations highlight some of the complexities that propel the suicidal act and belie a false dichotomy that has driven the "nature vs. nurture" debate since time immemorial.

Suicide remains enshrouded in a fog of stigma that further exacerbates survivors' grief and increases their risk of adverse outcomes. Actual or perceived stigmatization by individuals within a survivor's sphere of influence may be particularly insidious for child survivors for whom social validation is of critical importance. One study examined unwritten "rules" of bereavement and found participants who interacted with suicide survivors often felt more constrained by such unwritten rules and were therefore unable to convey empathetic support as freely as they would to individuals bereaved by other losses (Calhoun et al., 1986). This finding suggests, but does not confirm, suicide survivors who receive fewer expressions of support from friends and associates might erroneously view it as a manifestation of stigma and process it accordingly.

Risks specific to family members of suicide victims warrant further analysis, and future investigations should reveal additional factors to be considered in public education and prevention initiatives. Findings to date affirm what common sense and standard clinical practice have long understood. Suicide is neither a solitary act nor a phenomenon to be understood solely in the

see Loved One on page 20

Addressing Suicidality in Older Adults: A Community-Based Approach

By Catherine Thurston, LCSW
Chief Executive Officer
Service Program for Older People (SPOP)

In a review of data around suicidality, we see that older adults are highly vulnerable. The CDC reports that adults over age 45 account for more than 50% of deaths by suicide in the US, with the risk of suicide increasing with age. The national rate of suicide is highest among men over age 85 (45.9 per 100,000), and yet community-based mental healthcare programs for older adults remain scarce throughout the country.

At Service Program for Older People (SPOP), we are acutely aware of the risk of suicide and suicidality among older adults. SPOP is one of a handful of agencies across the country that focus entirely on community-based mental healthcare for older adults. Our overarching goal is to enable older adults to live their best lives, and we work in partnership with hospitals, aging services providers, and older adult centers to reach out to the most vulnerable and provide coordinated support.

Our clinic serves ages 55 and older, and many of our clients have at least one suicide risk factor, such as social isolation, chronic illness or pain, or complicated grief. Our clinical staff all receive training in protocols for treating suicidality, including a proprietary Distress Action Plan, which we developed as an alternative to traditional language to ensure a person-centered approach.

The Clinic has recently expanded staff capacity to provide trauma-centered psychotherapy and also launched two specialized programs for high-need clients: Enhanced Care, which offers short-term intensive intervention, and STRIVE, which provides individual case assistance, counseling, integration of addiction treatment and other aging-related services. These client stories show how our staff is addressing suicidality among older adults.

"Simon" is a 68-year-old male who came to SPOP to address symptoms of post-traumatic stress, suicidality, and social isolation. He is a 9/11 survivor and had received services in the past to treat his flashbacks, hypervigilance, and lack of motivation, but in recent months, was finding himself fantasizing about dying by suicide (car crash) and was worried that his disturbing thoughts, along with new sciatic pain that developed as he aged, might lead to a relapse of alcohol and cocaine use.

Using a holistic reflection on physical and emotional pain, his SPOP therapist provided education on the link between trauma and bodily pain. She encouraged Simon to see a physical therapist and join an exercise class at his local older adult center. She also taught him visualization exercises to practice while driving, helping him use dialectical behavior therapy skills to re-regulate when fantasizing about crashing. Simon has been practicing distress tolerance and has developed intentional phrases that he says out loud, reminding him of his overarching desire to get home safely.

Simon was ambivalent about talking through his fears of relapse and was concerned that talking about his urges with a professional would trigger an uncontrolled onslaught of cravings. His therapist connected him with an addiction treatment program where he was able to meet with a Certified Recovery Peer Advocate, who gave him tips on "urge-surfing" without having to speak with multiple recovery counselors.

After five months of treatment, Simon is now working to engage in a physically and socially active life. He takes his dog to the local dog run and reports that he hasn't had images of crashing his car in several weeks. He is looking forward to joining a DBT skills therapy group, where he can meet other people who have survived traumas and learned to trust their own bodies again.

Albert, age 66, worked at the NYC Metropolitan Transit Authority for 30 years. He came to SPOP two years ago for support in managing symptoms of depression, suicidality, and alcohol use. When he fell behind in rental payments and faced eviction, we enrolled him in our STRIVE program, which offers extra supports for high-need clients. The STRIVE team helped him apply for a grant to cover his rental area, connected him to an addiction treatment program, and encouraged him to enroll in a weekly mood-boosting activity program at his local older adult center. When his rental assistance application was denied, we encouraged him to present his case at a hearing, which ultimately led to a successful decision.

The team also helped him to complete applications for his MTA pension, the NYC Senior Citizen Rent Increase Exemption program, and transportation services. With SPOP's support, he is no longer suicidal, has achieved sobriety, and has secure housing.

Agnes is a 79-year-old woman who came to SPOP to help manage constant panic, tearfulness, and thoughts about suicide. She had no trust in her ability to cope with any of her intense feelings, felt isolated, and did not know how to get her needs met. Agnes was encouraged to enroll in SPOP's Enhanced Care program to receive additional weekly support from a secondary clinician and regular check-in calls from a social work intern. She had developed a relationship with her primary clinician, but she was hesitant to connect with additional team members, fearing that "the more people who know that I think about overdosing, the more people that are going to try to hospitalize me."

SPOP listened to her concerns, validated both her perceived loss of control as well as her actual loss of control, and confirmed that everyone's shared goal was to help put the client back into her own driver's seat. Agnes eventually decided to engage in Enhanced Care, where she designed her own Distress Action Plan (DAP), chose the affect regulation skills she wanted to learn and practice with her secondary clinician, and determined her intern call schedule. After eight weeks, Agnes reported a decrease in suicidal thoughts and is now consistently referencing her DAP when needed.

Suicide care and prevention for older adults is nuanced. We unequivocally want to make space for discussion and acceptance around death and dying; at the same time, however, we understand that older adults may have extreme ambivalence about dying by suicide. Our role as mental health professionals is to give them the freedom and support to talk about their pain while searching for reasons to live.

Catherine Thurston, LCSW, was appointed Chief Executive Officer of Service Program for Older People (SPOP) in July 2024, having previously served as Chief Program Officer for eight years. She has over 35 years of experience in gerontological social work, including serving as Chief Services Officer at SAGE/Service &

see Older Adults on page 39

Schools and Suicide Prevention: A 3-Tiered Approach

By Scott Bloom, LCSW
Director of Special Projects
New York Psychotherapy and Counseling Center (NYPCC)

Suicide is a complex issue with devastating consequences that disproportionately affect young people. Schools, as central hubs of a child's life, play a crucial role in suicide prevention by addressing behavioral and emotional difficulties that threaten to interfere with a child's ability to perform academically. Schools focus on factors affecting academic achievement, and mental health interventions work toward improving behavioral health outcomes in home, school, and community settings. While schools are not responsible for meeting all mental health needs of students, most educators agree that schools should enhance social-emotional competence, character, health, and engagement (Greenberg et al. 2003). By implementing comprehensive strategies, schools can create a supportive environment that fosters mental well-being and reduces the risk of suicide among students.

Understanding the Problem

Suicide is a multifaceted issue with various contributing factors, including mental health conditions, bullying, trauma, and social isolation. Suicide is the 2nd leading cause of death for people aged 12-24 in the US, with roughly 3,703 attempts each year by high school-aged youth (CDC, 2020). Suicide kills more youth per year than all natural causes combined. Youth suicide deaths increased by nearly 40% over the past decade (MAHNY, 2019). According to NAMI (2022), teens want schools to play a big role in their mental health; they should teach about mental health and how to get services. In a recent study, the percentage of NYC public high school students reporting feelings of sadness or hopelessness increased from 27% in 2011 to 38% in 2021(Hamwey, 2024). Schools are often the de facto means by which kids get any mental health supports, so the importance of ensuring students have multiple ways of receiving services is central when tackling suicide.

Schonfeld and Kline (1994) report on *two basic assumptions* when dealing with any school crisis. The first: *crisis situations are inevitable in a school setting*. They are going to happen, and schools need to be prepared. If you are a solo clinician in a school, then it's your job to make sure you know the protocols and procedures. The second basic assumption: *crisis involves people and their personal reactions to the situation. What keeps a crisis in operation is that it's not so much the incident but the reaction*. When someone is in a crisis, it's as if they have horse blinders on – they can only see what is in front of them. Anything else in the periphery is out of focus, out of consideration. Clinicians' goal when confronted with suicide is to assess risk, listen empathetically, encourage appropriate help, follow school protocols, and encourage follow-up. Recommended risk assessment tools include **Stanley-Brown Safety Planning Intervention** (2008, 2021). A brief intervention to help those experiencing self-harm and suicidal thoughts with a concrete way to mitigate risk and increase safety. **Columbia Suicide Severity Rating Scale** (Posner, 2010). A semi-structured interview/flexible format whose questions get the appropriate answer allows you to gather enough clinical information to determine whether to call something suicidal or not.

The Role of Schools in Suicide Prevention

Adopted from the medical model for prevention, the use of a multi-tiered system of supports (MTSS) approach when addressing suicide prevention aims to prevent behaviors and mental health symptoms from escalating. Through these targeted and individualized family-centered services, schools work to improve child functioning in order to prevent and reduce the risk of suicide. The MTSS model (AIR, 2024), broken into three tiers, is familiar to most school professionals, given that it is utilized for many school-based prevention initiatives. The following proactive approach highlights how a school can implement interventions so that anyone in a school can get the right help at the right time.

Tier I - Universal interventions promote awareness and training needs of all members of the school community, assessing school environment and climate for how protective factors can be enhanced while considering upstream prevention programs. Interventions include:

- Incorporate mental health education into the curriculum to teach students about emotional well-being, stress management, and coping skills.
- Promote open conversations about mental health, reduce stigma, and encourage help-seeking behavior.
- Train staff to recognize the signs of mental health struggles and intervene appropriately.
- Student suicide awareness education
- Provide regular training for teachers, administrators, and staff on suicide prevention, mental health awareness, and crisis intervention.
- Offer support and resources to staff members who may be experiencing stress or burnout.
- Fold in Mental Health Literacy education in Health Classes

Tier II - Selective Interventions include selective strategies concentrating on 1) groups who may be at higher risk, 2) students exhibiting warning signs, and 3) students experiencing stressful life events that may put them at elevated risk. Interventions at this level will include social supports and key target points in time when screening for suicide risk may be prudent.

Early Intervention and Support Services:

- Implement screening tools to identify students at risk of suicide or experiencing mental health difficulties.
- Establish crisis intervention teams to respond promptly to students in crisis.

see Schools on page 29

HUMAN DEVELOPMENT SERVICES of WESTCHESTER

"WHAT MATTERS TO YOU, MATTERS TO US!" | WWW.HDSW.ORG

Human Development Services of Westchester has been involved in the evolution of community-based direct-care services for vulnerable populations in Westchester County for over fifty years.

We provide strength-based, person-centered, culturally competent services for over 3000 people each year, through a unique blend of inter-related programs.

Dedicated to empowering the individuals and families we serve to achieve self-sufficiency, we are a social service organization providing quality behavioral health, rehabilitative, health, residential, and community stabilization services in Westchester County.

- The Living Room Crisis Day Respite Program
- HOPE House Clubhouse Program
- Transitional and Permanent Supportive Housing
- Eviction Prevention & Housing Counseling
- Home and Community Based Services
- Homeless Outreach
- Care Management Services
- Supportive Employment
- Supportive Education
- Social Engagement
- Peer Support

CREATING COMMUNITY SINCE 1968

HDSW - Main Office
930 Mamaroneck Ave,
Mamaroneck, NY 10543
(914) 835-8906

The Living Room
930 Mamaroneck Ave,
Mamaroneck, NY 10543
(914) 882-8659

HOPE House - Clubhouse
100 Abendroth Ave,
Port Chester, NY 10573
(914) 939-2878

Collaborative Care in Primary Care: Using Data to Prevent Suicide

By Virna Little, PsyD, LCSW-r, MBA, CCM, SAP, and Jian Joyner, LSW
Concert Health

Suicide remains one of the most pressing public health challenges in the United States. Over the past decade, suicide rates have risen alarmingly, leaving families and communities grappling with the devastating consequences of loss. Even more troubling is the evidence showing that nearly half of individuals who die by suicide visit a primary care provider within a month of their death (Luoma, Martin, & Pearson, 2002). This data underscores the critical opportunity to identify and support at-risk individuals within the primary care setting. Unfortunately, traditional approaches to suicide prevention—such as referrals to emergency departments or specialized mental health services—often fail to provide the timely, consistent care needed to reduce risk (Little & White, 2022). Many individuals never attend follow-up appointments, leaving their needs unaddressed.

This gap in care calls for innovative, evidence-based models like the Collaborative Care Model (CoCM), which integrates behavioral health support directly into primary care settings. CoCM provides an accessible, sustainable framework for delivering comprehensive care to individuals at risk for suicide. It ensures that patients can receive the mental health support they need within the trusted environment of their primary care provider's office.

The Collaborative Care Model: Evidence-Based and Patient-Centered

The Collaborative Care Model is a proven approach to identifying and treating behavioral health conditions, including depression, anxiety, and suicide risk. Developed by the AIMS Center at the University of Washington, CoCM is supported by more than 100 randomized controlled trials, making it one of the most rigorously validated frameworks in behavioral health care. At its core, the model emphasizes a team-based, measurement-driven approach that facilitates close coordination between primary care providers, behavioral health care managers, and psychiatric consultants.

At Concert Health, CoCM is implemented using a range of tools, including the Patient Health Questionnaire (PHQ-9), a widely used screening instrument for depression that also helps detect suicide risk. For individuals scoring high on self-harm indicators, further assessment is conducted using tools like the Columbia Suicide Severity Rating Scale (C-SSRS) or the Ask Suicide Screening Questions (ASQ). These tools enable early identification of suicide risk, ensuring that patients receive the appropriate level of care promptly and within a familiar environment.

Personalized Engagement and Flexible Care Plans

One of the key strengths of CoCM is its ability to provide consistent, personalized engagement with patients. High-risk individuals receive frequent follow-ups and support, including access to psychiatric consultations within the first week of care. This rapid response can be life-saving, as it addresses the urgent needs of individuals who might otherwise face lengthy wait times in traditional mental health systems.For patients with lower levels of risk, CoCM offers flexible, dynamic care plans that evolve over time, ensuring that interventions are tailored to meet individual needs.

For instance, a patient who initially presents with moderate risk may benefit from bi-weekly check-ins with a behavioral health care manager. If their symptoms escalate,

see Collaborative Care on page 27

Leadership's Responsibility for Postvention Following a Death by Suicide

By Andrew Pearson, MD
Chief Medical Officer
The Jewish Board

While society has grown more open to discussions centering around suicide - both its prevention and its impact on survivors - the subject remains fraught among mental health clinicians who have treated people who have died in this manner. The death of a client by suicide can elicit in providers shock, profound sadness, guilt, anger, and anxiety, the intensity of which may rival the welter of emotions felt following the death of a family member. Many clinicians, especially trainees and early-career therapists, experience dual bereavement in such circumstances: mourning the patient coupled with loss of professional self-perception as competent and capable. Some clinicians decide to leave the field entirely following a person in their care dying by suicide (Ellis and Patel, 2012).

Leadership within mental health organizations should develop clear policies and procedures that address suicide postvention, which staff can refer to when a patient dies by suicide. Because suicide is infrequent, many organizations lack these written structures, leaving staff to attend to grief in a haphazard manner at precisely the time when guidance is vital. This article outlines three fundamental components of suicide postvention: staff support, administrative tasks, and learning.

Staff Support

According to Anderson, 2007 and Alexander, 2005 (as cited in Ellis, 2012), mental health professionals often describe feeling isolated from colleagues in the wake of a death by suicide. Fear of judgment, blame, and inadequacy can overtake clinicians, especially among staff who overestimate their ability to control outcomes, hold themselves to perfectionist standards, or overly invest their own self-worth in their clients' wellbeing (Ellis & Patel, 2012). Prompt social support in which condolences and reassurance are offered from supervisors, mentors, and members of senior leadership can help mitigate the alienation clinicians encounter in the days and weeks following a death. It is paramount that the intent of these communications is to comfort the staff member, avoiding dissection of the record and possible missteps in treatment or safety planning. Examining the treatment course for lessons that could bolster suicide prevention within the organization will come later.

Debriefing in more depth with a supervisor--allowing space for discussion of the particulars of the case from the therapist's perspective and the emotional ramifications of the loss-- is recommended. Several conversations of this type may need to occur over weeks to ensure that the therapist has a forum to process how the tragedy has impacted their approach to therapeutic work, especially with clients who express suicidal ideation. These encounters can also help to identify staff members who may be vulnerable to complicated or prolonged grief, specifically those who have lost a family member or friend to suicide, have more porous boundaries between their personal and professional lives, or cloak their genuine feelings about the event out of fear or shame (Ellis & Patel, 2012). Linking the staff member to speak with a senior practitioner who has experienced the loss of a patient to suicide can help attenuate the isolation that many clinicians feel, giving them a longer view of how tragedies can deepen one's understanding of the work, especially the limits of professional influence. Leadership should ensure that staff

see Leadership on page 31

Suicide is NOT a Symptom

By Neil Leibowitz, MD, JD
Chief Medical Officer
Vita Health

Too many have lost a loved one to suicide. Every 11 minutes, someone dies by suicide in the US, often without warning.

Suicidality has historically been regarded as a symptom of major depression and mental illness in general. During my training, when someone was at risk of suicide, we were taught to treat the underlying mental illness, and the patient would get better. However, in many cases that has proven to not be correct.

In fact, a large percentage of severely depressed patients never think about suicide, and more than half of suicides occur independently of a known mental health condition. Moreover, many of those who attempt or die by suicide do so without warning, particularly those under 20 years of age.

Depression alone is not a clear indicator for the proper understanding of the complexity of suicide. As one of America's leading causes of death, it is imperative we understand the risk factors that lead to suicide and address them distinctly from concurrent mental health diagnoses or lack of them.

In many cases, those closest to the edge are often the ones who may seem furthest from it.

Addressing Suicide Independently

Suicidality results from a series of factors that can differ across individuals. A complex interplay of biological, clinical, neurological, and situational components. Chiefly, psychological pain, the burden of negative emotions including shame, guilt, fear, anxiety, loneliness, and angst, indicates suicidality as a behavior, as opposed to a symptom of depression.

Contrary to what one would think, the Crisis Text Line found that words such as 'ibuprofen,' '800mg,' and even a pill emoji correlated more with suicide than words such as 'depressed' and 'sad.' The presence of hopelessness (lack of positive expectations), including difficulty in believing that there are non-suicidal alternatives to life problems, provides a more reliable predictor of risk than depression.

We continue to learn more about those at risk of suicide. Variations in DNA also play a part. A recent study involving more than 29,000 individuals with a history of suicide attempts identified a genetic predisposition to suicide. Sharing an underlying biology with known, non-psychiatric risk factors such as sleep disorders, substance abuse, and pain suggests a common architecture between suicide attempts and these risk factors, not mediated by psychiatric illness.

Furthermore, research has revealed structural and chemical changes in the brains of people who die by suicide, such as alterations in the prefrontal cortex, which controls decision-making, and lower levels of serotonin, a key mood regulator. These changes have been observed regardless of whether the individual had depression, anxiety, or did not have a diagnosed mental health disorder.

Importantly, these findings indicate that suicidality can occur independently of other mental health conditions, underscoring the need to approach suicidality as a condition with a distinct program of care.

Current Healthcare is Missing the Mark on Suicide Prevention

Despite advances in understanding suicidality, our healthcare system isn't well-equipped to deal with its complexity. Many primary care providers miss critical warning

see Suicide on page 33

Loved One from page 14

context of the individual. It is, in short, a family affair, and survivors of such a grievous loss deserve the utmost empathy and support.

Ashley Brody, MPA, CPRP, is Chief Executive Officer at Search for Change, Inc, and can be reached at (914) 428-5600 (x9228) or abrody@searchforchange.org.

Ashley Brody, MPA, CPRP

References

Calhoun, L.G., Abernathy, C.B., & Selby, J.S. (1986). The rules of bereavement: are suicidal deaths different? *Journal of Community Psychology, 14*(2), 213-218. doi.org/10.1002/1520-6629(198604)14:2%3C213::AID-JCOP2290140212%3E3.0.CO;2-D

Coon, H., Darlington, T.M., DiBlasi, E., Callor, W.B., Ferris, E., Fraser, A., et al. (2020). Genome-wide significant regions in 43 Utah high-risk families implicate multiple genes involved in risk for completed suicide. *Molecular Psychiatry, 25*, 3077-3090. doi.org/10.1038/s41380-018-0282-3

Durkheim, É. (1897). *Suicide: A study in sociology.* The Free Press.

Jang, J., Park, S.Y., Kim, Y.Y., Kim, E.J., Lee, G., Seo, J., Na, E.J., Park, J-Y, & Jeon, H.J. (2022). Risks of suicide among family members of suicide victims: A nationwide sample of South Korea. *Frontiers in Psychiatry, 13*, 1-10. doi.org/10.3389/fpsyt.2022.995834

Jordan, J.R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior, 31*(1), 91-102. https://doi.org/10.1521/suli.31.1.91.21310

Pfeffer, C.R., Martins, P., Mann, J., Sunkenberg, M., Ice, A., Damore, Jr., J.P., Gallo, C., Karpenos, I., & Jiang, H. (1997). Child survivors of suicide: Psychosocial characteristics. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(1), 65-74. https://doi.org/10.1097/00004583-199701000-00019

Pfeffer, C.R., Normandin, L., & Kakuma, T. (1994). Suicidal children grow up: suicidal behavior and psychiatric disorders among relatives. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*(8), 1087-1097. https://doi.org/10.1097/00004583-199410000-00004

How My Suicide Attempts Made Me a Better Crisis Peer Specialist

By Carl Blumenthal, MS, MA, NYCPS
Peer Specialist
Fountain House

Trigger Alert: If you or someone you know is disturbed by the descriptions of suicide (attempts) in this article, please consult a behavioral health provider or contact the 988 Suicide and Crisis Lifeline.

Carl Blumenthal, MS, MA, NYCPS

Past is Prologue for Premature Life and Death

Car crash, asphyxiation, throat slash, frostbite, overdose, electrocution, hunger strike. These are the seven "lucky" ways I tried to kill myself between 1974 and 2006. "Lucky" because my dramatic but half-hearted attempts left me alive with only one scar (on my neck). Had I stuck with one of these methods and perfected it, I wouldn't be here today at age 73.

However, my younger brother, Hank, who experienced anorexia as a young adult, starved himself to death at 66 in a nursing home 2 ½ years ago, after several attempts to do himself in by swallowing a tube's worth of toothpaste and a lot of the Adderall he used for his OCD.

The 988 Suicide and Crisis Lifeline lists eight risk factors for suicide. Although neither of us misused substances and we both had plenty of behavioral health care, we shared prior suicide attempts, mood disorders, access to lethal means, knowing someone who died by suicide, and chronic disease.

A key difference is that I was married and had many friends, whereas my brother lived alone without social support and depended first on our mother and, after she died, on me, who took care of him for the last four years of his life.

As for protective factors, Hank's behavioral health care wasn't effective in the long run, in part due to multiple diagnoses. It takes two to tango, and he wasn't always a therapeutic dance partner. My attempts to support him using my peer specialist skills tended to make him dig deeper into a hole. When I finally removed the wall that he had built around himself by hoarding, he became more defensive.

Hank's self-esteem depended on his ability to get the best deals for himself—by haggling with merchants, scalping concert tickets, winning insurance injury claims, and gambling on the stock market. At his best, he was adventurous and put people at ease by acting as a clown because he relished his status as an outsider.

But, when he didn't get what he wanted from people emotionally, he often turned against them. His perhaps unconscious purpose in life was to use his brilliant mind to follow (hopelessly) in the footsteps of our brilliant father. Because our Jewish parents died before him, any religious belief against suicide was buried with them.

If I sound hard on Hank, it's because our lives mirrored each other's, beginning with us both doing time at the Yale Child Study Center for acting out. He spent a total of two years on psychiatric inpatient units; for me, it was only four months. I am the oldest of four, and while our two sisters had their problems, they did not become manifest until later in life. Plus, they both had children; neither Hank nor I did.

The roles that race, ethnicity, class, gender, etc. play in the risk/protective factor assessment are hotly debated. Being a middle-class, well-educated Jewish straight male seemed to help me, but not Hank. His failures in those regards made him feel like the odd man out in our family.

As the third child, Hank might have been overlooked, except his premature birth led to a "separation anxiety" so intense that our mother had little time for the rest of us. His cries for attention substituted for his inability to speak until the age of five.

Is it possible that this one adverse childhood experience (ACE) could wreak such havoc on me? Somehow, I and my two sisters lived up to the expectations of our father, who graduated from Yale University at age 19 and became a successful businessman. While my mania fueled overachievement, when depression didn't sideline me, Hank's multiple diagnoses crippled him ultimately.

Our mother was no slouch either. A graduate of Brooklyn College, she became a grammar school teacher and social worker after raising us. As president of our community mental health center, she persuaded me to become a peer specialist. The sad irony is that neither of us could save Hank from himself, parts of whom were embedded in her and me. Mom's parting words were: "Take care of each other!" To me, that meant assuming her lifelong guilt. Ouch!

see Peer Specialist on page 30

When Outpatient Psychiatric Care Is Not Enough

By Eric M. Plakun, MD,
and Thomas Franklin, MD
Group for the Advancement
of Psychiatry (GAP)

Yolanda and Vi met when they arrived on campus and were assigned as roommates in the freshman dorm. As they got to know one another, they learned they each struggled with depression and suicide, early trauma, and both had been in a psychiatric hospital in the past. Both had histories of alcohol and drug use as well.

As a result of pandemic isolation, both Yolanda and Vi had lost out on social experiences, learning how to develop relationships with others and being part of a group. Both also had the experience of family members being concerned about their pattern of substance use.

Despite her challenges, Yolanda thrived in the first semester. With the help of therapy and medication, she attended sessions regularly, built a strong rapport with her therapist, addressed past traumas, stayed drug-free, attended classes enough to earn good grades, and developed friendships that reduced her isolation.

Vi struggled to attend sessions or use them effectively, having difficulty trusting her therapist. Once a good student, she now missed classes, neglected assignments, and became isolated, spending time on video games or social media. While her drug use decreased, her struggles continued, and she eventually left school after a suicide attempt and hospitalization.

Back home, Vi had trouble holding a part-time job, getting to therapy sessions, or to the groups that were part of an intensive outpatient program (IOP). She remained isolated, with few social contacts. A course of transcranial magnetic stimulation (TMS) offered little benefit. Vi tried returning to school after a semester away, but her difficulties recurred.

The stories of these two fictionalized college students might leave one wondering why Yolanda seemed to thrive while Vi continued to struggle, though they had similar struggles, access to good therapy, and appropriate medications.

Should a person like Vi give up her dream of graduating from college? What other options might help her take charge of her life?

Treatment Means Recovery, Not Just Crisis Stabilization

According to SAMHSA and the federal courts, the generally accepted goal of treatment is not mere crisis stabilization but recovery. Hospitals are essential for crisis stabilization, but the pursuit of recovery is generally the focus of outpatient treatment.

Consider a comparison from the world of medicine and surgery. After a stroke, patients are first hospitalized for crisis stabilization, then transition to outpatient care for recovery. If they have lost basic abilities, they go to an intermediate-care level to regain skills before returning to outpatient treatment. A similar approach applies in mental health, where residential treatment acts as an in-between phase after crisis stabilization. It's like using training wheels on a bike—helping patients build skills for independent recovery.

Outpatient Treatment Doesn't Always Work

As a result of her successful pursuit of recovery as an outpatient, Yolanda did not need a bike with training wheels. She had mastered two important skills by the time she got to college.

First, she was able to show up reliably and form an alliance with her therapist. Treatment included meetings about

see Outpatient on page 33

Confronting Seasonal Depression: The Critical Role of the 988 Lifeline, Community, and Support Systems During the Winter Months

By Tia Dole, PhD
Chief 988 Suicide & Crisis Lifeline Officer
Vibrant Emotional Health

The holiday season, typically marked by joy and togetherness, can also be a challenging period for many individuals coping with loss, trauma, or loneliness. Seasonal depression, also known as Seasonal Affective Disorder (SAD), often intensifies as the days get shorter and the weather becomes colder. While maintaining one's mental health is crucial year-round, it becomes especially critical during winter months. This seasonal struggle can have devastating consequences, including an increase in suicidal thoughts and actions.

SAD, often casually described as the "winter blues," can be a debilitating mental health condition that is much more than a simple seasonal mood shift. According to psychiatric research, SAD is often caused by reduced exposure to sunlight in the fall and winter months, which disrupts sleep cycles and adversely affects individuals' serotonin levels. For many, this leads to persistent melancholy and fatigue throughout the season. Loneliness and isolation can worsen these emotions, especially for those without close relationships with family or friends during the holidays.

Nearly 24% of individuals diagnosed with a mental illness report that the holiday season significantly worsens their condition, while 40% experience a moderate decline in their mental well-being. These "holiday blues" can escalate into more severe mental health issues, such as clinical anxiety or depression, according to a 2023 National Alliance on Mental Illness (NAMI) study.

As SAD and clinical anxiety continue to affect communities across the U.S., there is a concerning potential for an increase in suicide attempts. Individuals without strong, reliable support systems of family and friends may feel particularly overwhelmed, sometimes leading them to consider drastic measures. Moreover, the lack of community support systems can exacerbate feelings of isolation around the holidays when daily routines are disrupted, and conversations often center around family gatherings and holiday celebrations.

Recent data shows 13.2 million adults reported seriously considering suicide, and 1.6 million adults reported making a suicide attempt. From the same data, nearly 50,000 lives were lost to suicide in one year – that's one every 11 minutes.

Even for those who do have a support system, these byproducts of depression can be difficult to deal with, not only for the individuals struggling but also for their families, friends, and colleagues who want to help but aren't sure how.

In this context, the 988 Lifeline emerges as an essential resource, providing a lifeline for those struggling with SAD or other serious mental health conditions. The 988 Lifeline is a necessary, effective resource available to everyone, free of charge. Offering confidential support 24/7 via call, text, and chat plays a crucial role in reducing the stigma around mental health, which can prevent individuals from seeking the help they need and deserve. Since its launch in 2022, the 988 Lifeline has responded to over 10 million calls, texts, and chats from people across the United States and territories.

see 988 Lifeline on page 35

Black Women and Suicide: The Silent Crisis and Its Aftermath on Families

By Shanika L. Wilson, DSW, LCAS, LCSW,
Associate Professor in Social Work
North Carolina Central University

Suicide among Black women is a heartbreaking and complex issue that has often been overlooked in public health discussions. Despite the cultural narratives of strength and resilience surrounding Black women, they face mental health challenges that are deeply rooted in historical and social injustices. These pressures, while hidden behind a mask of survival, can become overwhelming. When a Black woman takes her life, the pain doesn't end with her—it echoes through her family and community, leaving lasting emotional and psychological scars.

A Growing Crisis: Suicide Among Black Women

For many years, it was believed that suicide rates among Black women were lower than in other groups. However, recent studies show that suicide rates among Black women, especially those between 15 and 24, have increased dramatically. From 2013 to 2019, suicide rates in this age group doubled, revealing a rising crisis that demands attention (Gordon, 2021). These numbers aren't just statistics—they represent the loss of daughters, sisters, mothers, and friends whose deaths devastate their families and communities. It is crucial to understand the factors contributing to this growing crisis so that effective interventions can be developed.

The reasons behind this rise are multi-faceted. Black women experience a unique combination of pressures related to race, gender, and social inequality. Often, there is an unspoken expectation that they must be strong at all times, suppress their emotions, and keep going, no matter the obstacles. While this "strong Black woman" narrative has roots in survival, it can also silence Black women's struggles, leaving them feeling isolated and overwhelmed. The stress of navigating racism, sexism, economic hardship, and gender-based violence can lead to mental health struggles like depression and anxiety, which are often untreated or dismissed. A 2020 study published in *JAMA Psychiatry* found that Black women who faced racial discrimination were significantly more likely to have suicidal thoughts (Walker, 2020). This intersection of race and gender stressors points to the need for culturally sensitive mental health care that acknowledges these unique challenges.

The Heavy Burden of Silence and Stigma

One of the biggest challenges Black women face when dealing with mental health issues is the stigma that surrounds them. In many Black communities, there is still a perception that seeking help for mental health is a sign of weakness or failure. Instead of feeling free to share their struggles, many Black women internalize them. The idea of "pushing through" becomes an unhealthy coping mechanism, and asking for help may be seen as a betrayal of the cultural expectation of strength (Holland, 2018). This cultural expectation silences Black women's voices at a critical time, increasing their risk of mental health crises.

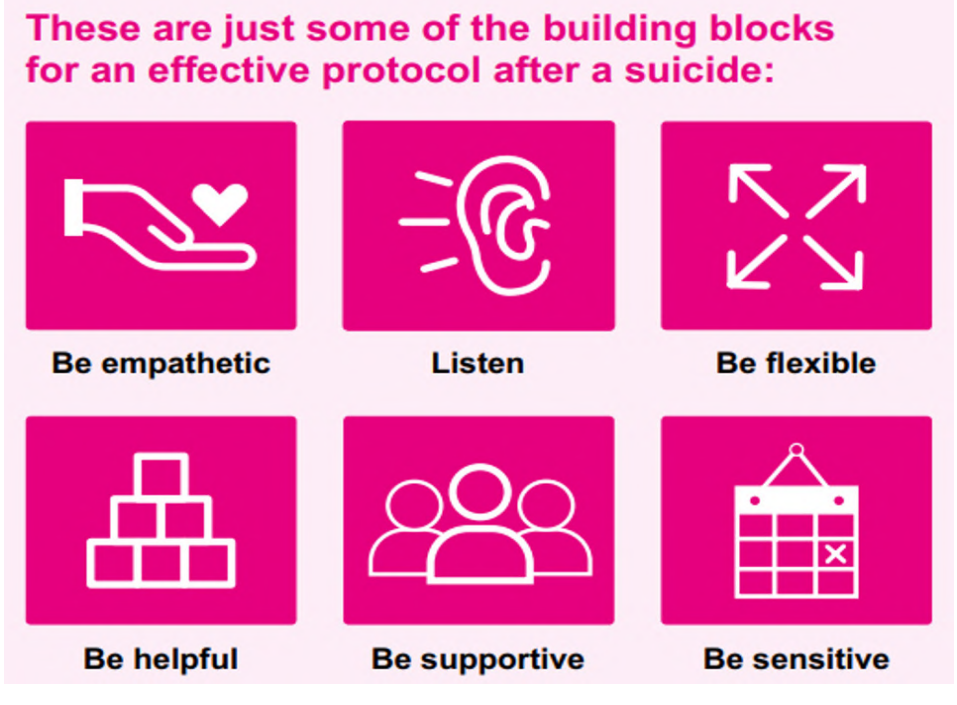
This stigma often intersects with religion and faith. While churches can provide

see Black Women on page 34

Saving Lives At Work: How Employers Can Lead in Suicide Postvention As Prevention

By Rachael Steimnitz
and Alayna Auerbach
National Alliance on Mental Illness
of New York City (NAMI-NYC)

It's OK to talk about suicide. The more we do so, the more we break down barriers that stop people from feeling safe enough to seek help. Vital strides have been made to open the dialogue on suicide. For example, the World Health Organization (WHO) Suicide Prevention Day theme for 2024-2026 is "Changing the Narrative on Suicide" with the call to action "Start the Conversation" about suicide, including actions employers can take to facilitate open and honest discussions. In addition, the U.S. Department of Health and Human Services released a 2024 National Strategy for Suicide Prevention, which builds upon the 2012 strategy with a "whole-of-society" approach and offers an expanded workplace section. These leading organizations, among many others, are increasingly calling on the critical role of all employers in suicide prevention. The majority of people who die by suicide are of working age (18-65), which makes the workplace uniquely positioned to reduce suicide risk. Employers in the National Alliance on Mental Illness of New York City (NAMI-NYC)'s Workplace Mental Health Collaborative convene to discuss how to operationalize workplace mental health best practices, including around suicide. Recent discussions have focused on how one step every employer can take is developing a strategy for when suicide crises occur.



These guiding principles enable a compassionate postvention plan that will "help you deal with a suicide, carry out your responsibility as an employer, assist your staff, be sympathetic to the individual, and be flexible enough to respond to the specific demands of the situation." More details are available in the full guide. Credit: Samaritans

"One year and we're still here" is the celebration motto of NAMI-NYC's free peer-led support group, demonstrating a safe space to talk about what it's like to have suicidal thoughts, how to manage them, and how to find community that is effective in suicide prevention.

Create a Suicide Postvention Policy

Each suicide has far-reaching impacts, including an average of six people being intimately impacted as "suicide loss survivors," and newer research showing an average of 135 people who knew the person and were "exposed," such as colleagues. Importantly, someone does not need to have a close relationship with an employee who died to be affected, and it is not possible for workplaces to know exactly who will be affected and to what extent. Therefore, workplaces need a suicide postvention plan, defined as support offered after a suicide crisis (e.g., death, attempt, behavior/discussion), to have a profound effect on preventing more suicides. To do so, employers can create a written policy for postvention support that ensures people

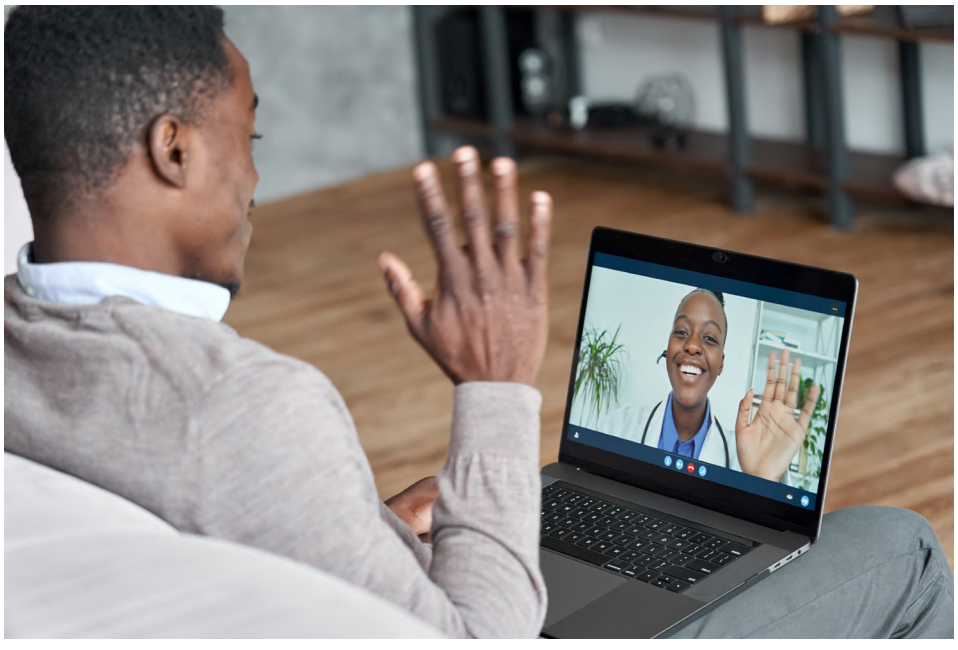
see Saving Lives at Work on page 32

Advancing Suicide Prevention: The Role of Technology and AI in Mental Health Care

By Mimi Winsberg, MD
Chief Medical Officer and Co-Founder
Brightside Health

Suicide rates in the U.S. have reached alarming levels, with 13.2 million adults experiencing serious suicidal thoughts annually, 3.8 million making a plan, and 1.6 million attempting suicide. These statistics reflect a public health emergency that demands urgent attention. Yet, access to quality mental health care remains limited, compounded by a nationwide shortage of providers, few of whom are equipped or willing to treat high-severity, high-acuity cases.

Mental health care is typically delivered in an episodic fashion, with patient assessments completed during regularly (or not, as the case may be) scheduled appointments. While valuable, this approach often fails to account for the rapid and unpredictable shifts in mental health that can occur between visits or just a lack of continuity in care. For individuals experiencing suicidal ideation, these gaps in care can be life-threatening. Real-time monitoring and timely intervention are crucial to addressing crises before they escalate. To effectively meet the challenges of treating higher acuity patients, we must transition toward proactive, technology-enabled care models designed to monitor and improve outcomes for those at risk.



Telehealth: Transforming Access and Equity in Mental Health Care

Telehealth offers one practical solution to this problem, breaking down barriers that have historically prevented access to mental health care. By enabling patients to receive care from the comfort and privacy of their homes, telehealth reduces both the stigma of a mental health visit and its logistical burdens, such as the time and cost associated with traveling to a clinic. For individuals in rural or underserved areas, telehealth has made high-quality mental health care accessible where it was previously unavailable.

Telehealth can do more than bridge geographic and socioeconomic divides; it can also leverage technology and data to deliver personalized, evidence-based care in innovative ways. Layering technology into telehealth platforms with, for example, the use of digital intakes, machine learning-based provisional diagnoses, and clinical decision support can aid clinicians in delivering tailored and effective treatment plans at the time of first symptoms.

Harnessing AI for Proactive and Personalized Suicide Prevention

Clinical decision support systems can be an integral part of a health technology solution and can aid in diagnostic accuracy, disease interpretation, and treatment selection. By analyzing a patient's history, symptom cluster presentation, and treatment responses, a data science approach can help predict which therapies are most likely to be effective for each individual. This overcomes the guess-and-check process that often frustrates patients and prolongs the time to remission. A study published in BMC Psychiatry found that precision prescribing led to clinically significant improvement in 86% of patients within 12 weeks. Moreover, clinical decision

see Technology and AI on page 39

Carmen Collado: Championing Community Care and Strategic Growth in Mental Health Services

By Staff Writer
Behavioral Health News

Carmen Collado, LCSW-R

Carmen Collado, LCSW-R, is a seasoned leader in the behavioral health field, recently appointed as Chief Operating Officer (COO) at Community Counseling & Mediation (CCM). With over 30 years of experience in human services, Collado brings a wealth of expertise in delivering compassionate, high-quality care across diverse communities in New York City. In her new role at CCM, a nonprofit dedicated to advancing mental health, housing, and educational programs, she joins President and CEO Douglas Brooks to oversee daily operations and execute strategic initiatives that address complex community needs.

Founded in 1982 and headquartered in Brooklyn, CCM provides an array of essential services to approximately 10,000 children, youth, adults, and families each year. Through its network of six mental health clinics, four supported housing programs, youth enrichment initiatives, and family support services, CCM is a linchpin in New York's human services sector. The organization's mission centers on empowering individuals from underserved backgrounds, helping them thrive through culturally responsive programs that foster stability, wellness, and self-sufficiency. CCM's commitment to its core values of competency, empowerment, respect, and advocacy resonates deeply with Collado's approach to leadership.

Collado's past roles have uniquely equipped her for this new challenge. Most recently, she served as Chief Relationship Officer for The Shield Institute, an organization supporting children and adults with autism and developmental disabilities. During her tenure, she made impactful contributions by reorganizing, rebranding, and expanding the footprint of Pure Vision Arts (PVA), an art program of The Shield Institute, where she increased access for neurodivergent artists and integrated behavioral health services. "Watching the artists gain a sense of pride and seeing their contributions celebrated was truly inspiring," Collado shared.

PVA is Manhattan's only full-time studio dedicated to artists with neurodevelopmental conditions such as autism. Collado's work with PVA helped generate new revenue, enabling broader outreach while preserving PVA's mission to empower artists through self-expression and economic opportunities. This transformative experience exemplifies her dedication to inclusive, holistic programming, a commitment she carries forward in her work at CCM.

Before her tenure at The Shield Institute, Collado held key positions at the Institute for Community Living (ICL), where she developed crucial partnerships with managed care organizations, government bodies, and peer organizations, securing over $1.75 million in funding to sustain supported housing programs. Her initiatives included promoting cultural competence within the agency, aligning policies with the diverse populations served, and fostering stronger community connections. Additionally, as Chief Government and Community Relations Officer at Jewish Board of Family and Children's Services, she led the JBFCS Foster Care Initiative, which reduced disruptions in foster care placement

see Carmen Collado on page 33

The Heavy Burden of Survivor's Guilt: Understanding, Coping, and Moving Forward

By Lorna Wittenrich, MA, QS, LMHC
Director of Clinical Services
Dupont Counseling Group

Family, friends, and even mere acquaintances are left with a wide range of feelings after someone in their life commits suicide. Feelings of responsibility, regret, and helplessness manifest in a complex experience called Survivor's Guilt. This painful guilt grows from a sense of intense remorse felt by loved ones who are burdened by the "what if" mindset. These thoughts can be paralyzing, leaving survivors questioning their actions or inactions in the wake of an unimaginable loss.

But first, it's important to point out that suicide continues to be one of our country's most disturbing health problems. The Centers for Disease Control and Prevention's latest statistics show that more than 49,000 people committed suicide in 2022. (American Foundation for Suicide Prevention, n.d.) Think about this: for every person who dies by suicide, there are likely more than 60 others – family, friends, and loved ones – left struggling with guilt and loss. (Centers for Disease Control and Prevention, n.d.) That's more than 2,940,000 people potentially suffering from the heavy weight of Survivor's Guilt.

This experience can be isolating. Yet, research shows that those who are grappling with these feelings, suicide-loss survivors, are far from alone. By better understanding the roots of this guilt, individuals can begin to process and ultimately overcome it.

One of the most common questions that stems from Survivor's Guilt is "What if?" After someone commits suicide, loved ones are often left wondering, "What if I had noticed something sooner?" or "What if I had reached out?" Often, suicide-loss survivors are left with a need for understanding or control. That is a common psychological response to trauma, as individuals often seek explanations to restore a sense of order to their lives.

By finding a reason for a traumatic event, individuals feel less vulnerable, as they believe they can anticipate or prevent similar occurrences in the future. This may be particularly true for parents whose children commit suicide. They may be desperate for answers so the same doesn't happen to their other children. The effects of Survivor's Guilt can also reach as far as neighbors, teachers, and coaches.

However, reeling over the "what ifs" and "whys" can lead to increased anxiety, obsessive thinking patterns, and even depression. It's important to gently remind ourselves that this choice was not ours to make. No one person holds all the power over another's life. (Bolton, n.d.)

Unresolved trauma combined with guilt can also deepen feelings of self-blame. This internalization of guilt can prevent healing, as it places the responsibility solely on the survivor, even when there was nothing they could have done. The psychological link between the two is powerful; the more a person feels responsible for the loss, the harder it becomes to move past it.

In order to heal, people need to switch the focus from self-blame to self-forgiveness. This process recognizes that, while it is natural to wish we could have done more, the reality is that we cannot change the past. Self-forgiveness does not mean excusing or minimizing what happened, but rather, it's about releasing the burden

see Survivor's Guilt on page 37

Protecting Youth Mental Health: The Role of Families in Addressing Social Media's Impact on Self-Harm and Suicide

By Abraham Abdulrazzak, DO and Samuel Jackson, MD
SUNY Downstate Health Sciences University

Emma was a 14-year-old high school freshman, a creative and outgoing student with a passion for photography. She had no prior mental health concerns and was thriving academically and socially. When she received her first smartphone, social media quickly became a way for her to connect with friends and share her photos. Websites like Instagram and TikTok initially felt like a positive space for self-expression.

Social media has become intertwined with the experience of adolescents, becoming a rite of passage for many teenagers. It has the ability to shape how youth connect, communicate, and even define their identity. While platforms like TikTok, Instagram, and Snapchat can act as modalities for self-expression, literature, and data increasingly suggest that problematic social media use has profound negative impacts on youth mental health. Calls from the U.S. Surgeon General and professional societies urged society to better understand the impact of social media use on youth mental health and childhood development.

Over the past decade, diagnoses of mental health conditions among young people have soared, mirroring an unprecedented demand for treatment and a rise in youth suicide rates. Most notably, according to epidemiological studies, the timeline of the youth suicide crisis overlaps with the meteoric ascent of social media. Families are at the frontline of addressing social media's impact on youth mental help and can play a vital role in prevention, intervention, and recovery.

Social Media and Mental Health: A Complicated Relationship

Social media is not inherently harmful. For many teens, social media can act as a platform for activism, creative expression, and a means to find support. LGBTQ+ youth, for example, often connect via online communities for affirmation and understanding, which they may lack in their "offline world" or day-to-day environment.

However, for many young people, social media may be problematic. Often conceptualized as excessive use, problematic social media consumption correlates with increased reports of anxiety and depression in adolescents. Passive social media use has been found to directly aggravate depressive symptoms, like loss of interest or depressive mood, and negatively impact personal well-being (Cataldo et al., 2021). The more time spent and the greater the frequency of use, the sharper the decline in mental health for youth (Zubair et al., 2023).

Designed to captivate and maximize engagement, algorithms that power social media platforms may promote sensational or emotionally charged content (Logrieco et al., 2021). According to a recent study, adolescents engaging in this type of content are at higher risk of internalizing harmful messages, creating a negative feedback loop (Nesi, J., & Prinstein et al., 2015). Adolescents, whose developing brains are sensitive to dopamine rewards, are particularly vulnerable to these mechanisms. They may find it increasingly difficult to disengage—even as their mental health begins to suffer.

see Social Media on page 36

Prolonged Grief and Suicide Survivors: Understanding Risks and Treatment

By Thomas Grinley, MS, MBA, CMQ/OE, LSSGB, CCISM, Health Services Evaluation Planning and Review Specialist, Bureau of Program Quality, Health Services Assessment Unit, NH Dept. of Health and Human Services

NOTE: The terms complicated grief, traumatic grief, and prolonged grief are essentially synonymous. They are used interchangeably here based on the sources being cited and terminology used in those sources, eventually settling on prolonged grief as it appears in the DSM-5-TR and the ICD-11.

The concept of complicated grief was first developed by Prigerson et al. (1995a). The Inventory of Complicated Grief they developed measured maladaptive symptoms of loss that had "been shown (a) to be distinct from bereavement-related depression and anxiety, and (b) to predict long-term functional impairments" (p. 65). The concept was recognized in the DSM-5 for further study (American Psychiatric Association, 2013) and added to the DSM-5-TR as prolonged grief (American Psychiatric Association, 2022). Google Scholar returns 146,000 results for complicated grief between the introduction by Prigerson et al. (1995a) and publication of the DSM-5-TR in 2022. Clearly, the concept was recognized as an important addition to diagnostic tools. That is not to say the addition of prolonged grief to the DSM was without controversy. Eisma (2023) cited issues with distinguishing prolonged grief from normal grief, pathologizing grief, and problems of validity with assessments.

Prigerson et al. (1995b) defined complicated grief as "the failure to return to pre-loss [*sic*] levels of performance or states of emotional wellbeing" (p. 23). Suhany et al. (2021) describe acute grief as most common, followed by integrated grief as individuals adapt to their loss and return to pre-loss functioning. They further highlight that 7-10% of individuals will experience long-term functional impairment of complicated (prolonged) grief. Moore and Freeman (1995) quickly recognized the applicability of complicated grief for counseling survivors of suicide. Ruocco et al. (2022), decrying the lack of attention to the impact of suicide on survivors, found that survivors had increased risk for anxiety, PTSD, depression, complicated grief, and suicide. Shear (2015) pointed out a greater risk of complicated grief after a violent death, such as suicide.

Prolonged grief disorder in adults, as described by the DSM-5-TR (American Psychiatric Association, 2022), "represents a prolonged maladaptive grief reaction that can be diagnosed only after at least 12 months…have elapsed since the death of someone with whom the bereaved had a close relationship" (p. 323). The DSM also specifies the duration and intensity of bereavement must be outside social, cultural, and religious norms.

A great addition to the DSM-5-TR (American Psychiatric Association, 2022) is the "association with suicidal thoughts or behaviors" section for each diagnosis in the DSM. For prolonged grief disorder, the DSM states, "Individuals with symptoms of prolonged grief disorder are at a heightened risk for suicidal ideation, even after adjustment for the effect of major depression and PTSD" (p. 326). We also know that suicide

see Grief on page 37

The Overlap of Substance Use Disorders and Suicide: Key Insights and Intervention Strategies

By Temitope Fabayo, BA, MBA
President
DMC HomeCare

Substance Use Disorders (SUDs) coupled with suicide are a critical dual concern that has severe implications for the public health of the entire world. The National Institute on Drug Abuse (NIDA) also reports that people with SUDs are more prone to suicide, with statistics showing that their risk is six times higher than that of a non-addicted population. However, a report by USA FACTS shows that in the US, for example, about 46,003 people died by suicide in 2022, out of which about 30 percent met the criterion of alcohol or drug use. These alarming statistics highlight the urgent need for effective interventions and the role families and friends can play in supporting those affected. Substance abuse and suicidal behavior are often interrelated due to common factors like mental illnesses, isolation, and trauma that make it challenging to stop the cycle without intervention.

The Overlap Between Substance Use Disorders and Suicide

SUDs began to affect brain chemistry and kill off neurons, explicitly relating to serotonin and dopamine, which regulate moods. Substance dependency persists with diminished concentrations of serotonin; all of these affect the individual's ability to process emotions and put him at risk of developing depression and anxiety issues. These mental health conditions are significantly associated with suicidal ideation, meaning that the use of substances makes mental health worse and vice versa.

Also, alcohol and opioids distort judgment and self-control, provoking many virtually negligent actions, including self-harm. Studies presented in the Journal of Psychiatry & Neuroscience also demonstrate that under the influence of substances, the ability to predict outcomes is diminished, and attempting suicide during crises is more likely.

High-Risk Groups and Factors

Demographic Considerations - Specific populations are more at risk for co-occurrence of SUDs and suicide than others. According to the USA Facts, the suicide rate among the American Indian and Alaska Native communities is nearly double the national average; this is attributed to high substance dependency coupled with restricted access to mental health services. Veterans are also one of the high-risk populations, and it is estimated that 20 veterans commit suicide each day, and many of them have alcohol dependence or misuse.

Socioeconomic and Environmental Factors - Challenges like poverty, unemployment, and housing insecurity often drive individuals toward substance use as an escape, perpetuating cycles of despair. The stigma surrounding mental health and addiction further isolates individuals, deterring them from seeking help.

Intervention Strategies to Address the Crisis

Early Detection and Screening - Standard assessment for suicidality should be performed in people with SUDs. Practitioners

see Key Insights on page 38

Assisting Grieving Families to Find Closure While Maintaining Compliance with HIPAA

By Elaine M. Edelman, PhD, LCSW, CASAC-Adv, Kansas State University and Christopher Ste. Marie, JD
Community Health Action of Staten Island (CHASI)

The most fundamental goals of Harm Reduction and Buprenorphine Programs are to keep people alive and safe. Despite the best efforts of a very dedicated SUD workforce, over 107,000 people died of overdose deaths in 2023. Behind every overdose death is a family or friends in mourning. Often, they are left with questions and are searching for answers. As harm reduction professionals, we want to assist grieving families in finding the answers they need, but we must maintain the privacy of those we have served. It is a painful and confusing moment when a professional says to the family of an overdose victim, "I can't speak to you because of HIPAA." This is of no comfort to a family dealing with loss.

Having dealt with the families of overdose victims and seeing the hurt and anger at an inability to share information, the following steps were developed to *help connect a family with the information they may need to understand what has happened and to find closure.*

Begin with, "I am so sorry for your loss." This may seem obvious, but anxiety and fear of saying the wrong thing often keep people from acknowledging the very painful reality.

Ask the family (or other person you may be speaking with) what they may know about your connection to the client. It is *NOT a HIPAA violation to repeat what the person is already aware of.* For example, if a family member says, "I know Joey went to your program," you would not be disclosing anything the person was not aware of. *As long as you don't confirm or deny that the person was in your program, you are not committing a HIPAA violation.*

If the person you are speaking with is unaware of why their family member was coming (perhaps they did not know of a substance or mental health problem), inquire about how they came to know about your program (was there an appointment in the phone of the deceased? A bill from your program? Someone told them they saw the person at your program?). Partial information leads to unresolved questions on the part of the family. While you cannot confirm or deny the person's participation in treatment, it is *NOT a HIPAA violation to share publicly available information, such as what your program's mission is.* This may help the person "connect the dots" as to what has happened. Our goal is to diminish distress on the part of those we serve and *lead people to helpful information without disclosing specific health information, which is NOT a HIPAA violation.*

***It is always ok to share publicly available information*, including the goals of your program or practice, even if the person was unaware of why "Joey" was coming to you.** This *is not a HIPAA violation because what programs and clinicians do is available to the public and is NOT protected health information.*

Try to ascertain what the family already knows. In a recent conversation with the

see HIPAA on page 31

Addressing Suicide in Marginalized Communities: Unique Challenges and Culturally Responsive Approaches

By Oyindamola Williams, LMSW
Child and Family Therapist
Southwest Community Health Center

Suicide continues to remain a global crisis, claiming over 700,000 lives annually (WHO, 2021). In the United States alone, more than 49,000 people died by suicide in 2022, marking it one of the leading causes of death in the nation (CDC, 2023). Behind these sobering statistics lies an often-overlooked reality. Marginalized communities face unique challenges that significantly elevate their risk of suicide. From systemic inequalities to cultural stigma, the barriers to mental health care in these communities are vast and multifaceted. Addressing these issues requires more than conventional strategies, such as increasing mental health awareness campaigns or expanding general access to healthcare. While these efforts are important, they often fail to account for the unique social, economic, and cultural dynamics that marginalized communities face.

Marginalized Communities

Marginalized communities are groups of people who face systemic barriers and social exclusion due to their race, ethnicity, gender, sexual orientation, socioeconomic status, immigration status, or other aspects of their identity. These communities often experience disparities in access to resources, opportunities, and rights, leaving them vulnerable to various forms of discrimination and disadvantage. Racial and ethnic minorities often encounter systemic racism that affects their education, employment opportunities, and healthcare access. Similarly, LGBTQ+ individuals face stigma and rejection in various facets of life, from their families to the workplace. Immigrants, particularly those who are undocumented, frequently navigate a world of uncertainty, facing language barriers, xenophobia, and limited access to services.

Marginalization doesn't just mean being excluded from mainstream systems; it means carrying the burden of societal inequities. These inequities manifest in tangible ways, such as higher poverty rates, limited healthcare access, and reduced educational opportunities, all of which have a profound impact on mental health. Marginalized individuals often live at the intersection of multiple disadvantages, a concept known as intersectionality. For instance, a Black transgender woman may face the combined effects of racism, transphobia, and gender discrimination, amplifying the challenges she experiences.

Understanding the Challenges

What makes the plight of marginalized communities particularly urgent is that the consequences of exclusion are not just economic or social, but they are deeply psychological. Persistent feelings of being alienated or devalued can lead to chronic stress, anxiety, and depression, increasing the risk of mental health crises, including suicide.

Among immigrants, the stressors begin long before arrival. Pre-migration trauma, including violence, persecution, or displacement, leaves many immigrants grappling with Post-Traumatic Stress Disorder. A meta-analysis revealed that the prevalence of suicidal ideation among refugees alone is 20.5% (BMC Public Health, 2022). Once in their host countries,

see Marginalized on page 35

Collaborative Care from page 18

the care plan can be adjusted to include more frequent contact or additional psychiatric support. This adaptability is crucial for addressing the complex and often fluctuating nature of behavioral health conditions.

Outcomes That Save Lives

The impact of Concert Health's Collaborative Care services is evident in the outcomes achieved. Among patients identified as at risk for suicide, 76% who engaged in six months or more of CoCM care demonstrated significant reductions in their risk levels (Little et al., 2024). Additionally, over 2,100 patients successfully transitioned to safer risk levels during their care episodes.

In total, approximately 15% of patients in Concert Health's care are flagged for suicide risk, and 40% of these individuals show measurable improvements by the time they are discharged. These statistics highlight the life-saving potential of CoCM and its ability to deliver meaningful results for individuals and families.

Scalable and Sustainable Solutions

CoCM is not only effective but also highly scalable. Recognized as a reimbursable benefit by Medicare, Medicaid, and most commercial insurance plans, it has the potential to transform behavioral health care delivery on a national scale. Concert Health's ability to provide both virtual and in-person services further enhances its accessibility, particularly for underserved or rural populations where traditional mental health resources may be limited. This flexibility ensures continuity of care, regardless of geographic or logistical barriers.

Virna Little, PsyD, LCSW-r, MBA, CCM, SAP

Jian Joyner, LSW

Building Resilience Beyond Immediate Risk

While CoCM excels in addressing immediate suicide risk, its long-term benefits are equally noteworthy. By incorporating safety planning and ongoing engagement into the care process, the model fosters resilience and stability for patients over time. High-risk individuals benefit from weekly interactions with care managers and regular psychiatric consultations, creating a robust support system that reduces the likelihood of future crises. Meanwhile, patients with lower levels of risk receive continuous monitoring and tailored interventions, ensuring that their recovery is supported at every stage.

This sustained engagement not only improves patient outcomes but also strengthens the relationships between individuals and their primary care providers. By addressing behavioral health needs within the primary care setting, CoCM breaks down barriers to mental health care and empowers families to navigate complex emotional challenges with confidence and support.

Transforming the Future of Suicide Prevention

As more health systems adopt the Collaborative Care Model, the potential to improve suicide prevention efforts becomes exponential. By integrating behavioral health into primary care, CoCM offers a proactive, patient-centered approach that fosters trust, accessibility, and hope. It not only saves lives but also provides individuals, families, and communities with the tools they need to heal and thrive.

Virna Little, PsyD, LCSW-r, MBA, CCM, SAP, is Co-founder, and Jian Joyner, LSW, is Research Assistant at Concert Health.

For more information about Concert Health and its suicide prevention efforts through the Collaborative Care Model, visit concerthealth.com or contact Dr. Virna Little at virna@concerthealth.io.

References

Little, V., & White, C. (2022). Collaborative Care as an effective intervention for primary care patients at risk for suicide. *Journal of Health Care for the Poor and Underserved, 33*(3), x-xii. https://doi.org/10.1353/hpu.2022.0098

Little, V., Hardy, C., Green, B., & Fuller, S. (2024). *Addressing suicide risk: A study of dose response in Collaborative Care*. JG Research and Evaluation, Concert Health, and the Bowman Family Foundation.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *The American Journal of Psychiatry, 159*(6), 909-916. https://doi.org/10.1176/appi.ajp.159.6.909

Federal Policy from page 10

strategies and sources of support that the person can use in the event of experiencing thoughts of harm to themselves or others." As noted in the final PFS rule, basic components of a safety plan include: (i) recognizing warning signs of an impending suicidal crisis or actions that increase the risk of suicide; (ii) employing internal coping strategies; (iii) utilizing social contacts and social settings as a means of distraction from suicidal thoughts and/or taking steps to reduce the risk of suicide; (iv) utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; (v) contacting mental health professionals, crisis services, or agencies; and (vi) making the environment safe, including restricting access to lethal means, as applicable.[5]

To permit practitioners to perform and bill for this code, CMS created a new Healthcare Common Procedure Coding System (HCPCS) code designated as G0560, as follows:

G0560 (*Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal or substance use-related crisis; employing internal copies strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts or risky substance use; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe)*

G0560 may be performed by any practitioner authorized to furnish services for the diagnosis and treatment of mental illness, including physicians, psychiatric nurse practitioners, clinical social workers, mental health counselors, marriage and family therapists, and clinical psychologists. This standalone code can be billed in 20-minute increments and also will be eligible for payment when furnished via telehealth. G0560 is expected to be valued similarly to code 90839, the 60-minute code for psychotherapy for crisis, due to the similar levels of intensity.

Rachel A. Fernbach, Esq.

Post-Discharge Telephonic Follow-up Contacts Intervention

CMS has also approved new HCPCS code G0544 to prevent adverse outcomes and address the increased risk of suicide in the 12-month period following an emergency department visit for mental health issues, including self-harm, intentional overdoses, or suicidal ideation. This code is intended to provide reimbursement for telephone contacts with a patient following discharge, as follows:

G0544 (*Post-discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter per calendar month)*

This code can be used in any situation where a patient has been discharged following a crisis encounter, such as an emergency department visit, inpatient admission, or crisis stabilization service, and a telephone number has been provided to the billing practitioner upon discharge. The goals of this new service are to (i) encourage the use of a safety plan if needed during a crisis; (ii) update the safety plan to ensure effectiveness; (iii) express psychosocial support; and (iv) facilitate engagement in follow-up care. G0544 will be payable even if G0560 (Safety Planning Intervention) was not previously furnished or billed for the same patient. A patient must consent to the receipt of the telephone contact at least during the initial call and must be notified that Medicare cost-sharing may apply.

G0544 will be a bundled billing code comprised of four calls per month, each lasting between 10-20 minutes. However, G0544 may be billed only if at least one real-time telephone interaction actually occurs during the month – unsuccessful attempts to reach a patient by telephone will not count for billing purposes. This code will not be eligible for telehealth services.

Digital Mental Health Treatment

To further enhance access to supportive behavioral health services, CMS has also approved reimbursement for digital mental health treatment, which are devices approved by the Food and Drug Administration and "intended to treat or alleviate a mental health condition" in conjunction with ongoing behavioral health treatment. Coverage will be provided for mental health treatment interventions that have a "demonstrable positive therapeutic impact on a patient's health." These devices include smartphone apps, text messaging, email, and online forums that offer convenient access to mental health support and self-management tools, such as symptom tracking, habit formation, targeted change in behaviors, and peer support. [6]

CMS has created three new HCPCS Codes for digital mental health treatment:

G0552 *(Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan)*

G0553 *(First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of DMHT device, including patient observations and patient-specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month).*

G0554 *(each additional 20 minutes of monthly treatment management services)*

G0552 will provide reimbursement for the cost of a digital mental health treatment device and initial education and onboarding in the use of the device. Coverage will be available only when a practitioner incurs the cost of a device furnished to the patient and when the use of a device is incident to the billing practitioner's professional services furnished in association with an ongoing treatment under a plan of care. Medicare coverage will not be available if the practitioner incurs no costs in acquiring and furnishing the device to the patient or if the patient procures the device on their own.

It is exciting that SAMHSA and CMS are working to implement policies and strategies intended to prevent suicide and increase access to essential behavioral health services among groups that are disproportionately impacted by suicide. Government efforts to promote awareness and disseminate information to the public about prevention, intervention, treatment, and postvention support are truly valuable. Safety plans, follow-up calls, and use of digital mental health tools have the potential to create life-saving supports for those at increased risk of suicide or intentional overdose. The next steps must include efforts to ensure that Medicaid and commercial insurance also cover these critical safety net services.

Rachel Fernbach, Esq. is the Executive Director and General Counsel of the New York State Psychiatric Association and a Partner of the firm Moritt Hock & Hamroff LLP, where she concentrates her practice in the area of not-for-profit law and health care law with a specialty in psychiatry and other mental health services.

References

1. www.samhsa.gov/blog/changing-course-suicide-launch-new-national-strategy-suicide-prevention

2. Id.

3. www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other

4. Id.

5. Id.

6.www.psychiatry.org/psychiatrists/practice/digital-mental-health

Trust and Safety from page 13

risk factors associated with suicide and resources available in suicide prevention that can help treatment providers increase support for individuals at risk of suicide. A combination of refined, site-specific training and partnerships with external training organizations supports best practices in suicide prevention. CCBHCs participate in the New York State Office of Mental Health's Zero Suicide (ZS)[5] initiative. ZS makes available a range of training courses for all staff types, focusing on communication, lethal means awareness, and evidence-based practices that lead prevention efforts. Beyond CCBHCs, S:US Clubhouse staff are trained in safeTALK[6], which emphasizes the importance of recognizing the signs of someone at risk for suicide, communicating with the individual, and getting help, including resources such as the 988 Suicide and Crisis Lifeline. All Recovery and Treatment programs at S:US are invited to participate in safeTALK, recognizing the value of risk workshops, crisis counseling, and more.

Cultivating practices that broaden recovery lenses leads to an attuned ability to

James Chavez, LCSW

Dani York, LCAT, RDT

respond swiftly and effectively to suicidal crises. Through purposeful collaboration with networks of support, intentional interdisciplinary team engagement, and continued education via research and training, suicide can be prevented. Reducing the incidence of loss for family, friends, and community, in addition to strengthening hopeful narratives with individuals, is a most meaningful venture. S:US aims to destigmatize experiences, deliver interventions that prioritize safety, and seek to decompress the high stress and intensity of a suicidal crisis for staff, individuals, and their larger community of supports.

James Chavez, LCSW, is Regional Director of Treatment & Recovery, and Dani York, LCAT, is Director of Clinical Support and Enhancement at Services for the UnderServed (S:US).

To learn more about Services for the UnderServed's approaches to care, visit sus.org, call (212) 633-6900, or email info@sus.org.

References

Suicide statistics | American Foundation for Suicide Prevention

Columbia-Suicide Severity Rating Scale (C-SSRS) | Columbia University Department of Psychiatry

Forms - Stanley-Brown Safety Planning Intervention

Behavioral Health Services

Homepage | Zero Suicide

LivingWorks safeTALK - LivingWorks

Schools from page 16

Creating a Supportive School Climate:

- Foster a positive and inclusive school culture that promotes respect, empathy, and kindness.
- Implement anti-bullying programs to address bullying and cyberbullying, which can contribute to suicidal ideation.
- Encourage students to participate in extracurricular activities and build strong social connections.

Tier III- Targeted Interventions are focused on individual students that are acutely affected by a suicide loss, are engaging in suicidal behavior, or are demonstrating acute suicide risk. Provide access to mental health professionals, such as counselors and psychologists, who can offer individual and group therapy. Schools collaborate with community mental health services, such as the *New York Psychotherapy and Counseling Center,* for those students whose short-term counseling may not be sufficient. They can offer psychiatric evaluation, medication management, and ongoing play or psychotherapy for the student and family members.

Effective Suicide Prevention Programs:

Several evidence-based programs have demonstrated success in reducing suicide risk among young people:

- **Sources of Strength:** This peer-led program empowers students to promote positive mental health and connect with supportive adults and peers. sourcesofstrength.org/
- **Youth Mental Health First Aid:** This training program teaches adults how to identify, understand, and respond to signs of mental health challenges in young people. mentalhealthfirstaid.org/population-focused-modules/youth/

Scott Bloom, LCSW

- **Question, Persuade, Refer (QPR):** This training program equips individuals with the skills to recognize the warning signs of suicide, persuade someone in crisis to seek help, and refer them to appropriate resources. qprinstitute.com/

Postvention

The death of a student due to suicide presents many challenges to the school community and is often overlooked as part of the school response. The complex nature of suicide grief, the sudden, unexpected, and often violent aspects of this kind of loss, and the difficulty we have understanding and talking about suicide create circumstances that can leave school leaders in shock and struggling to meet the needs of staff and students (SPCNY, 2019). Preplanning is key in order to effectively deal with the post-crisis. Written protocols, policies, well-defined roles, and professional development specific to suicide loss are essential supports that enable school leaders and crisis team members to respond in a coordinated and effective manner. *After a Suicide: A Toolkit for Schools,* published in 2018 by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, contains many resources to be used in the immediate aftermath of a suicide death.

Demands and daily problems in schools produce a sense of urgency, and when suicide attempts or ideation occur, it makes the culture of schools more reactive than proactive and more remedial than preventive. Implementing a 3-tier mental health program and utilizing external clinical staff can assist in creating order in an environment that is often unorganized and fragmented. By pre-planning, schools can help prevent suicides and meet the needs of all students when they feel there is no one else to turn to.

Scott Bloom, LCSW, is Director of Special Projects at New York Psychotherapy and Counseling Center. He can be reached at SBloom@nypcc.org, www.nypcc.org, or 347-352-1518.

Resources

- JED Foundation
- The Trevor Project
- American Foundation for Suicide Prevention
- Suicide Prevention Resource Center
- Suicide Prevention Center NY
- Lifeline/Crisis Text Line: 988

References

Adrain, M, Lyon, A. Suicide and Self Harm Prevention in Schools. SAMSHA. 2018

AIR. Center on Multi-Tiered System of Supports. 2024. https://mtss4success.org/

American Foundation of Suicide Prevention. https://afsp.org/suicide-statistics/. December 2022

CDC. Risk and Protective Factors for Suicide. April 25, 2024 https://www.cdc.gov/suicide/risk-factors/index.html

CDC. Schools are the Right Place for a Healthy Start for Adolescents. CD. https://www.cdc.gov/healthyyouth/about/why_schools.htm

Greenberg, M. T., Weissberg, R. P., O'Brien, M. U., Zins, J. E., Fredericks, L., Resnik, H., & Elias, M. J. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist, 58*(6-7), 466–474. https://doi.org/10.1037/0003-066X.58.6-7.466

Hamwey M, Norman C, Suss R, et al. The State of Mental Health of New Yorkers. New York City Department of Health and Mental Hygiene. May 2024.

National Alliance on Mental Illness. Poll of Teen Mental Health from Teens Themselves. 2002. https://www.nami.org/support-education/publications-reports/survey-reports/poll-of-teen-mental-health-from-teens-themselves-2022/

Posner, K. et al. Columbia-Suicide Severity Rating Scale. June 2010. https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf

Schonfeld, D. J., & Kline, M. (1994). School-based crisis intervention: An organizational model. *Crisis Intervention & Time-Limited Treatment, 1*(2), 155–166.

Stanley, B. & Brown, G. The Stanley-Brown Safety Plan (2008, 2021). www.suicidesafetyplan.com

Suicide Prevention Center of New York State. A Guide For Suicide Prevention in New York Schools. 2019.

The Recovery Village. https://www.therecoveryvillage.com/mental-health/self-harm/self-harm-statistics/. 2024.

Peer Specialist from page 21

Back to the Future (Of Suicide Prevention Practice and Policy) at NYC Well

Little did I know that these experiences would prepare me to work for Vibrant Emotional Health's NYC Well and VNS Health's Brooklyn Mobile Crisis Team (BMCT). After 27 years as a community organizer, urban planner, and journalist, I became a peer specialist in 2002.

But it wasn't until the COVID pandemic that I came out of retirement, at age 69, to serve the needs of peers in crisis. At first, I failed to become a COVID contact tracer, and the Samaritans rejected me as a hotline volunteer, apparently because they believed my prior suicide attempts would trigger me.

However, Vibrant viewed my lived experience as an asset and hired me. There, I only worked the noon-to-8 PM shift on Mondays, Wednesdays, and Fridays because responding to a couple dozen calls, chats, and texts a day was enough to burn out the coolest peer support specialist.

I'll never forget my first day of work when I discovered so much suicidal and homicidal rage in visitors to the hotline that I could have written the script for a horror movie. Fortunately, my supervisor talked me down from the ledge of quitting.

Over the next two years, I became so adept at supporting peers in crisis that I could handle two suicidal texters or chatters at a time, even one in French and another in English, from as far away as Montreal and Mumbai. Of the thousands of interactions during that time, I was triggered by only a few peers whose self-absorption reminded me of my brother. Nor did the past suicides of extended family members, friends, and other peers inhibit my work.

Because I was as old as the grandparents of tweens and teens, I developed a special rapport with them when the isolation of remote learning during Covid worsened tensions between them and their parents.

That I survived multiple suicide attempts was usually the basis of building trust with suicidal visitors. My safeTALK (Tell, Ask, Listen, and KeepSafe) training gave me the confidence to be supportive as well as safety conscious.

Even when a peer contacted me in the middle of a suicide attempt, the ambivalence that I had experienced during my own attempts was the key to their survival. In conversations that lasted up to 90 minutes, I would reinforce the positive, usually unacknowledged, aspects of their lives while validating the pain of their present existence. In other words, I accentuated protective factors to compensate for risks. Then, we would plan a way forward.

Among the several hundred with suicidal thoughts whom I successfully supported, I got one young man to lock his gun in a safe and a young woman to untie the noose around her neck. (Follow-up by crisis counselors confirmed their survival.)

However, my support for suicidal peers ended in April 2022 when Vibrant instituted the Columbia-Suicide Severity Rating Scale (Columbia-SSRS) for screening peers in crisis. Although the six-question scale is an easy-to-use tool, peer specialists were instructed to transfer the interaction to a crisis counselor if the person in need answered "yes" to one of the first two questions: 1) Have you wished you were dead or wished you could go to sleep and never wake up? and 2) Have you actually had any thoughts about killing yourself?

The reason for this change in protocol was liability. Peer specialists are only certified, whereas crisis counselors are licensed clinicians. Unfortunately, it deprived me of my raison d'etre as a peer specialist supporting suicidal peers. That is why I became a member of VNS Health's Brooklyn Mobile Crisis Team and eventually resigned from NYC Well in October 2023, after it transitioned to NYC 988.

According to Vibrant, "All crisis counselors within NYC 988 come from diverse backgrounds, including those with lived experiences. Their role is to adhere to the 988 Lifeline's safety assessment guidelines, the imminent risk policy, and other clinical standards while utilizing the least invasive interventions necessary to support the individuals in crisis. In addition, NYC 988 provides access to an internal Peer Support Warmline, a call-only referral service.

We acknowledge that peer support is vital within the crisis continuum of care. When a help seeker contacts NYC 988 and speaks with a crisis counselor, they are assessed for suicidality and imminent risk. If there is no presenting risk, the caller can be connected to the Peer Support Warmline either by requesting to speak with a peer support specialist or, after further assessment, the crisis counselor suggests it as one of the next steps."

For all the operational sense this procedure makes, peer specialists have not only been further excluded from supporting suicidal peers directly but are also prohibited from text and chat interactions. Because Vibrant oversees the national 988 system and NYC 988 is the flagship local call center, this sends a discouraging message to other centers.

Although not well documented, it's possible that some local 988 centers use peer specialists to support suicidal peers, as implied in "Peer Support Services Across the Crisis Spectrum" by Amy Brinkley and Justin Volpe of the National Association of State Mental Health Directors, for SAMHSA in 2024. SAMHSA's other guidance on this subject is inconsistent. Sometimes, the agency only refers to "crisis counselors;" sometimes, it mentions "people with lived experience" and even volunteers as potential workers. However, SAMHSA is silent about whether peer specialists can support suicidal peers. (Prior to 988, the National Suicide Prevention Lifeline prohibited employment of peer specialists due to the focus on suicide.)

But don't take my word for the importance of peer support in suicide prevention. Here's what the National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force reported in "The Way Forward: Pathways to Hope, Recovery, and Wellness With Insights From Lived Experience," 2014: "Peer support workers—specifically peers who are survivors of a suicide attempt and/or survivors of suicide loss [both true in my case]…can offer understanding, compassion, and awareness of the possible range of thoughts and emotions the person in crisis is likely feeling and thinking. The person with prior lived experience will also have an understanding and knowledge of what worked for them in their own moment of crisis, which can help quickly build trust and connection with the person in crisis.… The peer support worker can also model self-care practices and provide a unique and powerful contribution to another person's recovery."

Due to the shortage of 988 crisis counselors nationally and their high burnout rate, SAMHSA should devise a way to balance liability and the benefit of support by peer specialists during suicidal crises.

Back to the Future II: VNS Health's Brooklyn Mobile Crisis Team (BMCT) for Adults

VNS Health solved the liability problem by pairing me with an experienced licensed social worker or nurse practitioner on visits to adult peers' homes. BMCT for adults is one of six MCTs VNS Health runs in Brooklyn, Queens, and the Bronx for peers of all ages. Approximately 20% of the 4,325 individuals referred annually by 988 to VNS Heath have exhibited some risk of suicide. Of those served, 60% are under the age of 21. Some drug overdoses may be suicide attempts, but these are decided case by case.

BMCT's clinical staff for adults was so caring, efficient, and effective in their practice (as were all the crisis counselors at NYC Well with whom I worked) that, at first, I had difficulty defining my role.

And, because the referrals are almost always from third parties, such as doctors, family, friends, and neighbors, the peers we encountered were free to refuse our services if they were even at home. Therefore, only during responses to peers who were suicidal did my experience at NYC Well kick in. Safety is the ultimate concern for mobile crisis teams. However, I found that I could differ with my partner clinician about whether, how, and when a person required transport to an emergency room.

In our most memorable response to a peer threatening suicide by subway, even though he was alone at home, we first meditated together to reduce his anxiety about returning to a hospital that he felt had mistreated him in the past. Then, before giving him time to pack, I advocated with my partner to allow the peer to pay his rent that would be due during his time away. These validations of his autonomy were key to his acceptance of transport by EMS to the hospital.

According to Deirdre DeLeo, VNS Health's Director of Behavioral Health Programs, "Data collected by NYC DOHMH [show] 5 to 10% of individuals seen by a mobile crisis team required transport to an emergency room for assessment for admission, which is a positive sign that the program is effective in managing cases safely."

She also described the clinician-peer specialist partnership this way: "I often compare the cooperation in MCT to dancing, where each partner has their own steps, but the true beauty is when the steps come together. This collaborative approach allows each person to play their role during an assessment…. Peers play a unique role in modeling resiliency and recovery in action. Discussing suicidal feelings and thoughts can be very difficult and scary. Peers may share their own journey and experiences…, which can be a relief and a confidence builder for our clients." DeLeo described one interaction in which a peer specialist convinced a skeptical young immigrant to accept treatment based on the peer specialist's own positive outcomes.

VNS Health has pioneered MCTs since 1987 and incorporates SAFE-T in the Columbia-CSSRS screening tool. SAFE-T is a five-step plan that involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk levels and interventions, and documenting a treatment plan. And safety planning, whether for suicide prevention or other concerns, is an important part of VNS Health's MCT practices.

Even with 20 MCTs for adults and five for children, NYC's capacity falls short of the need because New Yorkers still mostly rely on 911 to summon assistance for themselves and others during behavioral health crises. New York City is experimenting with a combination of EMTs and social workers who respond to 911 calls from 20% of precincts. The number of people served is small, and the teams don't utilize peer specialists.

In other words, we need to advertise 988 more fully as an alternative to 911, promote the NYC model of MCTs throughout the city and state with a full partnership of clinicians and peer specialists, plus adequately fund the system.

Conclusion: The Future is Now

I left my part-time position at VNS Health in October 2023 for a full-time one at NYU Langone's Brooklyn clinic for peers experiencing altered states of consciousness (aka "psychosis"). Now, I work as a peer specialist in Fountain House's Medicaid-funded community-oriented recovery and empowerment (CORE) program. Why am I still so passionate about the role peer specialists can play in suicide prevention?

Without glamorizing the misery of feeling and acting suicidal, I contend that the philosopher Friedrich Nietzsche was right when he stated, "What doesn't kill you, makes you stronger." I have learned how to harness my manic energy without risking a depressive blackout.

Raised as a Conservative, middle-of-the-road Jew, I became a member of the Protestant Religious Society of Friends (Quakers), in part because my numerous recoveries from depression and suicide attempts felt like resurrections. The 40 years my brother lived independent of institutions was his form of rebirth. Hank's inability to sustain that independence is a cautionary tale that guides my practice as a peer specialist.

Now that I'm thriving after 50 years of living with bipolar disorder, every day is a new beginning. We don't have to go to the moon to declare that one small step by any of us is a giant leap for all of us.

Contact Carl Blumenthal at carl-blumnthl@gmail.com. Carl is also a certified end-of-life doula who cooks for Transcendent Treats: Comfort Food for Life's Transitions.

Leadership from page 19

members are apprised of any employee assistance benefits offered by the organization so they can obtain, if needed, professional care and address any personal resonances a client's death carries for them that would not be appropriately discussed in a workplace environment.

Administrative Tasks

A complicated yet unavoidable dynamic occurs following a patient's suicide; staff reeling from the emotional fallout of the death must also contend promptly with numerous administrative and reporting responsibilities to regulatory bodies. Depending on the size of the organization and the scope of its services, these requirements may be difficult for staff to decipher and follow, especially if they have never submitted such reports in the past, compounding the stress experienced by staff members designated to fulfill this task. Leadership, specifically in compliance departments, can ease this burden by delineating very clearly in advance how and to whom deaths should be reported, as well as a timeframe for sending these communications and follow-up measures. Supervisors and managers may have more experience in these administrative domains, but they, too, can benefit from stepwise workflows pertaining to actions that must be taken following a death by suicide. While they may not have treated the client directly, they bear responsibility for supporting those staff who knew the client well, responding to staff distress, and serving as liaisons

Andrew Pearson, MD

to more senior leadership, all of which require substantial emotional resources. Clear direction regarding administrative responsibility and pressure increases the likelihood that reporting processes will be completed correctly.

In some instances, such as residential settings, it is possible that a staff member may need to notify the client's family of the death. Imparting this news may magnify many of the feelings already experienced by staff. Leadership should be cognizant of this difficulty and help the designated staff member prepare to make this call.

Organizational Learning

Gleaning lessons from suicide deaths is a vital part of postvention. Done with thoughtfulness, in a manner that eschews blame, examining the treatment course carefully can strengthen an organization's capacity to prevent future deaths while still respecting clinicians' sensitivities around the event. Reviews should not be completed in a cursory manner that glosses over missteps, as individual mistakes often stem from systemic processes that need refining (Ellis & Patel, 2012). For example, does the organization maintain clear directives about reaching clients who are transitioning from one level of care to another when deaths by suicide are statistically more likely to occur? Does staff know how to develop safety plans in a collaborative manner with clients so that the document becomes a true resource? Do risk assessments incorporate multifactorial elements that can contribute to suicidality, such as past attempts, substance abuse, and physical pain? A thorough analysis of the case with an eye toward identifying gaps such as these can galvanize improvements across the organization.

Who conducts the review and which sources are used in gathering information varies depending on the nature of the organization. Hospitals typically follow established Morbidity and Mortality protocols, while smaller institutions need to develop their own procedures that best suit their capacity (Ellis & Patel, 2012). Appointing a clinical leader who is not directly connected to the case to conduct the review ensures a measure of objectivity, which is necessary. Leaders might opt for the review to consist solely of a close examination of the chart or include conversations with treating clinicians and their supervisors, which can add more nuance and subtlety to understanding the treatment course, though care should be taken to approach these conversations in the spirit of learning and improvement, not criticism.

Formal reports should include the following elements: a description of the client's initial assessment and diagnosis; a narrative of the client's course; discussion of precursors, stressors, and chronology of events preceding the death; and reference to conversations held with relatives that occurred following the client's passing (Ellis and Patel, 2012). Clinical leaders should use this information to generate ideas for systemic improvement, comparing the findings between reviews to identify commonalities and ameliorate clinical and operational weaknesses in suicide prevention.

Knowledge about suicide postvention should be conveyed before clinicians need to rely on it. Having a codified approach to response to suicide helps sustain and care for staff and wrestles from tragedy ideas for improving care for clients most vulnerable to it.

Andrew Pearson, MD, is Chief Medical Officer of The Jewish Board. He can be reached via email at apearson@jbfcs.org.

Reference

Ellis, T. E., & Patel, A. B. (2012). Client suicide: What now? *Cognitive and Behavioral Practice, 19*(2), 277–287. https://doi.org/10.1016/j.cbpra.2010.12.004

HIPAA from page 26

daughter of a client who was found deceased a few days earlier, the daughter stated, "I know he was on 'films" (she was referring to the buprenorphine strips she found at her father's house). When asked what "films" were, she didn't know. The nurse she was talking to in the program asked her what was written on the package. She read, "b-u-p-r-e-n-o-r-p-h-i-n-e." Now that it was clear that she knew he was on this medication, staff could explain what it was.

When asked a specific question about their family member's adherence to their treatment, it is acceptable to answer the question in the form of standard operating procedure. For example, a family dealing with anger at the death of their son angrily asked our program if he had been attending sessions. He had not, but, as is standard operating procedure in a low threshold buprenorphine program, he was in regular phone contact with the staff. This would be an appropriate time to let the family know that there are HIPAA limits to what can be shared. However, it would be appropriate to say, "As a low threshold program, we are in regular

Elaine Edelman, PhD, LCSW, CASAC-Adv

contact with ALL our clients. If your son was in our program, then we would have had regular contact with him, even if he could not make it to the site." In this particularly sad scenario, the family remained angry that the program had not drug-tested him. A meeting was set up with the compliance officer (who is also a lawyer), who explained the protocols of a low threshold program. They were assured that all protocols were followed.

Christopher Ste. Marie, JD

In summary:

- Express sympathy about the loss
- Assess how much the family/contact person knows about your program, their loved one's connection to your program, and how much they were told.
- You can tailor your explanation of how your program works to their specific questions by citing the relevant protocols. Without sharing the person's specific health information, you can share that you and/or your program did everything that could be done.

It is important to remember that we serve not only our clients but their families and their communities. We must preserve our clients' privacy, even after death, but we must also help those who loved them find closure.

Elaine M. Edelman, PhD, LCSW, CASAC-Adv., is a Professor of Practice in the Department of Sociology, Anthropology, and Social Work at Kansas State University.

Christopher Ste. Marie, JD, serves as the Associate Vice President of Compliance at Community Health Action of Staten Island (CHASI). For more information, email Elaine at eleh@verizon.net.

References

www.hhs.gov/hipaa/for-professionals/privacy/guidance/health-information-of-deceased-individuals/index.html, accessed 5/15/24

www.samhsa.gov/find-help/harm-reduction, accessed 5/15/24

Saving Lives at Work from page 23

affected are reached in a timely, thorough, and clear manner. Many sample guidelines exist, such as:

- Crisis management in the event of a suicide: A postvention toolkit for employers
- A manager's guide to suicide postvention in the workplace: 10 action steps
- Responding to suicide risk in the workplace: A guide for people professionals

Include a Postvention Communications Plan

It can be challenging to know what to say when a suicide crisis occurs. Sometimes, employers scramble in the moment and do not say anything at all. Not talking about suicide perpetuates the message that it is taboo, ultimately causing employees who may be suffering to remain silent and avoid reaching out for help. Other times, employers worry that by speaking about suicide, they increase the risk of suicide contagion. However, there are safe and sensitive messaging guidelines to both encourage people to seek help and reduce contagion. An effective communications plan considers the following:

- Connect with the family in a timely, sensitive, and empathetic manner
- Abide by safe reporting on suicide and recovery-friendly language to avoid sensationalizing. Leave out information on the method used, location, notes, and photographs
- Release a statement that respects the family's wishes, offers condolences, shares resources for support, and any changes to schedules
- Equip senior leadership to talk about how they have personally been affected by the suicide to demonstrate it is not a sign of weakness to express feelings
- Distribute suicide grief and bereavement-specific resources to employees, including counseling, support groups, and hotlines, such as 988, the U.S. Suicide & Crisis Lifeline. Include information on what to do if you think someone is struggling

Center Compassion in Your Postvention Policy

Although suicide is prevalent, it is important to remember that there is a person behind every statistic. Employers should infuse compassion in all aspects of their postvention policy to ensure people are treated kindly and have the space they need to support themselves and others. Consider the following to build a compassionate environment:

- Offer to give the employee's personal items to their family
- Be flexible with bereavement leave policies
- Allow all employees time to attend memorials
- Offer tips to Human Resources and managers on how to practice sensitivity and empathy
- Foster meaning-making opportunities for employees to process responses (e.g., memorials, donations, getting involved)
- Prioritize your employees' wellness first. Once grief needs have been addressed, which can take months but depends on the circumstances, employees will be more ready to receive suicide prevention-focused efforts, such as training

Rachael Steimnitz

Alayna Auerbach

These guiding principles enable a compassionate postvention plan that will "help you deal with a suicide, carry out your responsibility as an employer, assist your staff, be sympathetic to the individual, and be flexible enough to respond to the specific demands of the situation." More details are available in the full guide.

Clarify Your Employee Assistance Program (EAP)'s Role in Critical Postvention Steps

Oftentimes, employers rely on their Employee Assistance Programs (EAPs) to provide crisis responses. This reliance on an external provider can make it unclear what the actual postvention policy and response is. To demystify and ensure quality, ask questions around:

- Immediate response: What is your protocol and timeline for responding?
- Communication: Do you assist with communicating and providing templates?
- On-site support: Do you offer on-site counseling services for employees?
- Counseling: Do you provide counseling and therapy services for affected employees and families?
- Support groups: Do you facilitate support groups for employees coping with grief and thoughts of suicide?
- Support for leaders: Do you provide training for managers and Human Resources on how to support their teams?
- Education: Do you provide any educational materials or resources on coping with grief and bereavement?
- Family support: What support services are available for the family?

Support Managers During Postvention

Managers have a complex role in supporting their staff and their own mental health in the aftermath of a suicide crisis. Taking extra steps to support managers helps alleviate some of the pressure:

- Host a specific debrief with managers after a suicide to provide additional information about how to support their staff, identify potential signs of distress, and share information about mental health resources
- Partner with external resources to take the burden off managers
- Highlight that difficulties after bereavement are not limited to emotions but also include problems with concentration and motivation
- Give managers latitude to make changes in workflow, such as additional time off or changing deadlines
- Encourage managers to be a role model for healthy grieving and acknowledge their own feelings regarding the loss of a colleague

Address Workplace Factors that may Undermine Postvention Efforts

Even if you create a thorough postvention policy, certain workplace factors can undermine postvention efforts by increasing suicide risk and decreasing help-seeking behavior. For example, a company culture that does not make employees feel comfortable taking time off for an appointment in the workday can prevent people from seeing the on-site grief counselor you bring in. High-stress and pressure jobs with long hours can hinder employees from coping and grieving. To alleviate this, educate leadership on the increased suicide risk for employees working long hours and provide protected time off for all employees. A culture of invulnerability where it's not "okay to not be okay" increases the chances that a struggling employee will try to push through and endure at work as opposed to reaching out for support. If employees feel they cannot show emotions in the workplace, to begin with, the chances of them thinking it is okay to show they are affected negatively are low. This leads to silent suffering. Having leaders model vulnerability by making a leadership statement of support after a suicide crisis, promoting help-seeking as a sign of strength, normalizing complicated feelings, and storytelling of lived experiences helps break down this facade.

Revisit Suicide Prevention Efforts

After employers develop a suicide postvention policy, it can be useful to take a step back and develop or enhance a suicide prevention strategy. Some employers focus on overall well-being and mental health without having a specific plan to prevent suicide. In-depth guidance is available, such as the Comprehensive Blueprint for Workplace Suicide Prevention by the National Action Alliance, which outlines eight areas to incorporate, as well as the Quick Start Guide, which breaks down the nine practices in the National Guidelines for Workplace Suicide Prevention into first steps employers can take to build momentum. Remember to promote the positive narrative and focus on solutions, such as actions people can take to prevent suicide, as opposed to problems. Include prevention-focused data, such as the number of people who reached out for help, to inspire hope and encourage others to do the same.

Every Employer can Start Today

The WHO has a goal to reduce the global suicide rate by one-third by 2030. Employers are pivotal in this process to create workplaces that effectively respond to suicide crises and prevent further risk through comprehensive and compassionate suicide postvention approaches. Suicide is preventable, and we all have a role. It is a great time to get started with a workplace campaign to reinforce that prevention works, effective help is available, and it's OK to talk about suicide. Within your campaign, educate employees on what to do if they see signs of suicide.

If you currently have thoughts of suicide, are a family or friend of someone living with thoughts of suicide, or are a suicide loss survivor, check out NAMI-NYC's free peer-led support groups. For emergencies in the U.S., call the 24/7 Suicide and Crisis Lifeline at 988. If you are a workplace and want to learn more on how to save lives through suicide prevention and postvention, reach out to NAMI-NYC's Workplace Mental Health Initiative today.

This article has been republished by permission. You may view the original article, published on September 6, 2024, at www.forbes.com/sites/forbeseq/2024/09/06/saving-lives-at-work-how-employers-can-lead-in-suicide-postvention-as-prevention/.

Rachael Steimnitz is Director of Workplace Mental Health, and Alayna Auerbach is Manager of Workplace Mental Health at National Alliance on Mental Illness of New York City (NAMI-NYC).

For over 40 years, the National Alliance on Mental Illness of New York City (NAMI-NYC) has helped individuals and families affected by mental illness through education, support, and advocacy. The NAMI-NYC Workplace Mental Health Initiative (WMHI) provides custom training and technical assistance to increase awareness and reduce stigma towards mental health in the workplace, create flexible organizational policies and facilitate open discussions about mental health, as well as ensure all employees and their families understand available company and community resources. To learn more, visit www.naminyc.org/workplace.

Suicide from page 20

signs, particularly in patients who do not exhibit mental health symptoms. This is especially concerning given that nearly half of those who die by suicide have visited a doctor in the month preceding their death. Additionally, like my training, most mental health professionals do not have any or sufficient training on both assessing and treating people at risk of suicide.

For those who have been hospitalized due to suicidality, studies indicate that the risk of suicide increases (conservatively) 400% following psychiatric hospitalization, with risk peaking in the period immediately after discharge. Yet many people are discharged to a community that is ill-equipped to manage their condition.

Current diagnostic practices also overlook the mix of biological, psychological, and situational factors that contribute to suicide risk. Moving forward, routine

Neil Leibowitz, MD, JD

screenings must evolve beyond explicit suicidal ideation, considering psychological distress, hopelessness, and biological predispositions.

Looking Ahead: Future Approaches to Suicide Prevention

Timely accessibility to clinicians specially trained in suicide is paramount.

Currently, only nine states mandate training in suicide assessment, treatment, and management for health professionals. While ensuring training will lead to better identification of those at risk, substantial training is needed to provide proper treatment. Suicide as a condition is a subspecialty that requires specific training; just like someone with an arrhythmia would be referred from a primary care physician to a cardiologist, someone at high risk of suicide should be referred to a clinician with sufficient training to both manage and reduce that risk.

Ensuring training across all clinicians would not only increase the availability of therapists nationwide to assist the huge numbers of suicidal individuals but also enable them to recognize the risk of suicidality in patients beyond depression.

Moreover, suicide prevention therapy must look to treat suicidality as distinct from other mental health diagnoses and focus on clinically validated care pathways, which have been shown to reduce attempts by 60% and deaths by 80% compared to treatment as usual (similar to the cardiology example cited above).

If healthcare is to provide effective assistance, suicide care, and intervention requires a more nuanced, comprehensive interpretation of risk factors beyond mood or affective disorders and a combined approach that enables access and provides an empathetic understanding of the mental pain experienced by individuals. It is only then that we will be equipped to truly 'treat' those at risk and reduce these needless deaths.

Neil Leibowitz, MD, JD, is Chief Medical Officer at Vita Health.

Outpatient from page 21

medications as well as weekly psychotherapy sessions. Second, Yolanda's recovery as an outpatient succeeded because of her ability to function adaptively between sessions.

Vi, on the other hand, struggled with those skills, and increasing outpatient therapy, medications, and skills training was not enough. She needed more support than outpatient care could offer. A residential program provided the necessary support for her challenges, allowing her struggles to become a focus of her treatment.

The combination of therapy and medications just wasn't enough for Vi. She needed more than outpatient treatment.

Thomas Franklin, MD

Eric Plakun, MD

Social Learning

For many individuals like Vi, adding social learning as a third form of treatment can make a difference. Learning in a twosome-like therapy extends to learning in the rest of life beyond the twosome.

However, as in the case of infants, development requires more than just face-to-face learning in a twosome with the mother. Infants also learn about the social world while safely held in a parent's arms, and they later learn much from peers.

The same holds true in the world of mental health treatment. Adding social learning to learning in a twosome (as in individual psychotherapy) and medication can boost mastery of skills in sessions and functioning adaptively between them. Adding outpatient group experiences may help, but Vi's work in an IOP while living at home just didn't provide her enough support.

Residential Treatment, Social Learning, and Medical Necessity

Social learning often requires immersion in a residential treatment center that combines peer support and group learning with individual learning in psychotherapy. Such settings focus on interpersonal growth and community-building, helping individuals break the cycle of loneliness and isolation.

Given Vi's lack of progress in IOP, a 24/7 residential program was recommended. The decision was supported by her score on the LOCUS (Level of Care Utilization System) assessment, which evaluates a person's mental health needs and indicates an appropriate level of care.

Residential treatment offers the best chance for Vi to overcome isolation and despair, fostering a sense of belonging. Over time, such an environment can help her address challenges that hinder outpatient treatment, improving her ability to engage in individual sessions and function better at school.

Difficulties Accessing Care

Access to residential treatment remains limited despite the federal parity law, which mandates coverage for mental health and substance abuse treatment equal to medical/surgical coverage, including intermediate care. Insurance companies often classify residential treatment as a short-term, crisis-focused service and resist covering it for recovery. This conflicts with nonprofit professional standards.

Vi's insurer initially denied coverage for residential treatment, but since she lived in a state like California or Illinois, where medical necessity is based on nonprofit professional standards, coverage was eventually approved. Vi's high LOCUS score demonstrated the need for residential care, helping her return to school and outpatient treatment better prepare her for success.

Unfortunately, no federal law links medical necessity to generally accepted care standards. Vi was lucky to live in a state that does. Does your state ensure access to medically necessary residential care based on professional standards? If not, consider advocating for laws that align medical necessity with nonprofit standards, not insurance company guidelines.

This article has been republished with permission. You can view the original source, published on December 5, 2024, at www.psychologytoday.com/us/blog/psychiatrys-think-tank/202412/when-outpatient-psychiatric-care-is-not-enough.

Thomas Franklin, MD, President and CEO of MindWork Group, and Eric M. Plakun, MD, former Medical Director and CEO of Austen Riggs, are both members of the Psychotherapy Committee at The Group for the Advancement of Psychiatry.

Group for the Advancement of Psychiatry (GAP) is a think tank of top psychiatric minds whose thoughtful analysis and recommendations serve to influence and advance modern psychiatric theory and practice.

References

Plakun, E." Clinical and insurance perspective on intermediate levels of care in psychiatry," J. of Psychiatric Practice Vol 24, No. 2, March 2018.

Plakun, E. "Psychotherapy, parity & ethical utilization management," J. of Psychiatric Practice Vol 23, No. 1, Jan 2017

Carmen Collado from page 24

through on-site mental health support for children—a model that later influenced statewide mental health policy.

Throughout her career, Collado has championed policy advocacy for vulnerable populations, working alongside policymakers, coalitions, and community leaders to effect meaningful change. Her efforts have included advocacy for Timothy's Law and mental health parity, children's mental health, and geriatric mental health services. These initiatives highlight her commitment to creating systemic improvements that uplift not only individuals but also the larger communities in which they live. In recognition of her contributions, Collado received the Latino Leadership Award from New York University's Center for Adolescent and Family Health in 2018.

With a staff of 325 and an annual budget of $25 million, CCM is poised for growth under Collado's leadership. The organization receives funding from several prominent agencies, including the NYC Department of Health & Mental Hygiene, NYC Department of Youth and Community Development, and the U.S. Department of Health and Human Services. Collado's strategic focus on fostering partnerships and ensuring high-quality, inclusive services will be instrumental in helping CCM expand its impact. "It's about building connections and creating spaces where people feel supported and empowered to reach their potential," she explained.

Collado's trajectory in human services demonstrates a commitment to advancing mental health and social equity through compassion, collaboration, and innovation. As she takes on this new chapter with CCM, her vision for sustainable, inclusive growth will undoubtedly shape the future of the organization and the lives of those it serves.

For more information, please contact Carmen at ccollado@ccmnyc.org and visit the Community Counseling & Mediation (CCM) website at ccmnyc.org.

Black Women from page 22

emotional and spiritual support, they can sometimes unintentionally contribute to the silence around mental health by framing struggles as a test of faith or character. Black women may be encouraged to pray or rely solely on their spiritual community instead of seeking professional mental health care. This delay in seeking help can allow mental health crises to worsen, sometimes leading to tragic outcomes (Boyd, 2020). Understanding how faith-based interventions can be combined with professional mental health services is key in creating holistic approaches that meet Black women where they are, both spiritually and emotionally.

Family Grief and the Ripple Effect

When a Black woman dies by suicide, her family is left to navigate a sea of conflicting emotions - grief, guilt, confusion, and often, a deep sense of shame. In many cases, families feel blindsided. They ask themselves, "How did we not see this coming?" or "What could we have done differently?" These questions can haunt them, leading to prolonged grief and even mental health struggles of their own. In the aftermath, families often grapple with cultural and societal expectations, which can prevent them from expressing their grief openly.

Black families often face the added burden of cultural stigma surrounding suicide, which can make it difficult to openly discuss the death. This silence can prolong the healing process, leaving unresolved emotional pain that affects family dynamics for years to come. Families may try to maintain the appearance of being "strong" for the sake of others, but inside, they are often struggling with feelings of failure and confusion. Open dialogue and mental health support are essential for families to begin the healing process, yet the cultural stigma often stifles this.

The Impact on Children and Future Generations

Children who lose a mother, aunt, or other female figure to suicide are left with an emotional void that is hard to fill. They may not fully understand the death and can be left with feelings of abandonment, guilt, or confusion. In Black families, where open discussions about mental health and suicide may not be the norm, children can grow up with unresolved questions and emotions. They may even internalize the message that showing vulnerability is dangerous or shameful, which can affect their emotional development (Smith, 2022). Without proper mental health support, these children are at a higher risk for developing mental health issues themselves, continuing the cycle of unaddressed trauma.

Shanika L. Wilson, DSW, LCAS, LCSW

This intergenerational impact is one of the most devastating legacies of suicide. When grief is not fully processed, or when families are unable to openly discuss their emotions, the trauma can be passed down. Children in these families may be at higher risk for developing their own mental health challenges or having difficulty forming secure relationships. To prevent this, it's essential that culturally responsive, evidence-based practices are implemented to support families and children in the aftermath of suicide.

Breaking the Cycle of Stigma

One of the most important steps in healing after a suicide is breaking the cycle of silence. Families need safe spaces to talk about what happened, process their grief, and heal together. However, in many Black communities, the fear of judgment or gossip prevents families from seeking help. Professional mental health care can make a huge difference, but many Black families do not trust the healthcare system, or they don't have access to culturally competent providers who understand the unique pressures Black women face. For instance, programs like *Healing Hurt People*, a trauma-informed, culturally responsive intervention, have shown success in helping families navigate grief and trauma after violent events, including suicide (Wong, 2020).

Thankfully, there are increasing numbers of mental health professionals who specialize in helping Black families through these complex emotions. Therapists who are trained in addressing racial trauma and family grief can provide a compassionate and culturally sensitive space for healing. For Black women, therapy can be a space to let go of the unrealistic expectation to always be "strong" and to embrace vulnerability as a path to healing.

Culturally Responsive, Evidence-Based Practices

Supporting families after a suicide requires culturally responsive, evidence-based practices that acknowledge the unique dynamics at play. Some approaches include:

1. **Culturally Sensitive Grief Counseling**: Programs like *The Loveland Foundation*, which provides therapy services specifically to Black women and girls, are essential in helping families process their grief in ways that are sensitive to their cultural experiences (Loveland Foundation, 2020). These services aim to break the silence and help families talk openly about their loss.

2. **Faith-Based and Mental Health Integration**: Recognizing the importance of faith in many Black families, integrating faith-based approaches with evidence-based mental health care can offer a path forward. For example, mental health organizations working alongside Black churches to offer counseling services can help bridge the gap between spiritual support and professional therapy (Boyd, 2020).

3. **Family Systems Therapy**: This evidence-based practice helps families understand how each member's experience is interconnected. Family systems therapy acknowledges the deep emotional bonds within Black families and helps them work through their grief collectively, fostering open communication and healing (Smith, 2022).

4. **Group Therapy and Peer Support**: Offering peer support groups where Black women and their families can share their experiences with suicide and mental health struggles can help normalize these conversations. Programs like *Sista Afya* provide community-based support, helping families find strength in shared experiences and empowering them to seek help (Sista Afya, 2021).

The Importance of Systemic Change

The solution to this crisis is not just about encouraging individual families to seek help—it's about changing the system that makes it difficult for Black women to access the care they need. Historically, mental health services have failed Black communities. Black women are less likely to receive adequate mental health care compared to their white counterparts (American Psychological Association, 2020). The reasons for this include financial barriers, a lack of trust in the medical system, and a shortage of culturally competent providers.

To address this crisis, we need systemic change. Mental health services need to be more accessible and affordable for Black women. Healthcare systems must prioritize training providers in cultural competency so they can offer care that acknowledges the unique experiences of Black women. Schools, workplaces, and community organizations also need to play a role by normalizing mental health discussions and reducing stigma.

Conclusion: Finding Hope Through Healing

The loss of a Black woman to suicide is not just a tragedy for her family—it is a community-wide loss that calls for urgent attention. We must recognize that Black women, despite being symbols of strength, need the freedom to be vulnerable and to seek help when they are struggling. Families who experience the devastation of suicide deserve compassionate, culturally competent care that allows them to heal without fear of stigma. Only by breaking the silence and addressing both the personal and systemic barriers to mental health care can we begin to address this hidden crisis.

Shanika Lavi Wilson, DSW, LCAS, LCSW, is Associate Professor in Social Work at North Carolina Central University.

References

American Psychological Association. (2020). Mental Health Disparities: African Americans. Retrieved from www.apa.org/.

Boyd, R. C. (2020). The Role of Faith and Stigma in Mental Health for Black Women. *HuffPost*. Retrieved from www.huffpost.com/.

Gordon, A. (2021). Why Are Suicide Rates Increasing Among Young Black Women? *The Atlantic*. Retrieved from www.theatlantic.com/.

Holland, J. (2018). The Pressure of Being Strong: Black Women and Mental Health Stigma. *Essence*. Retrieved from www.essence.com/.

Loveland Foundation. (2020). Therapy Fund for Black Women and Girls. Retrieved from lovelandfoundation.org/.

Sista Afya. (2021). Mental Wellness for Black Women. Retrieved from www.sistaafya.com/.

Smith, M. (2022). The Impact of Suicide on Black Families: Intergenerational Trauma and Healing. *Black Mental Health Today*. Retrieved from www.blackmentalhealthtoday.com/.

Walker, R. L., Salami, T. K., & Carter, S. E. (2020). Discrimination and Suicide in African American Women: A Longitudinal Study. *JAMA Psychiatry*, 77(8), 875-881.

Wong, A. (2020). Trauma-Informed Care for Grieving Families: Healing Hurt People. *Behavioral Health News*. Retrieved from behavioralhealthnews.org/.

Ripple Effect from page 8

interview mixed-methods study in Ireland. BMJ Open 2018;8:e019472.

Tal Young I, Iglewicz A, Glorioso D, Lanouette N, Seay K, Ilapakurti M, Zisook S. Suicide bereavement and complicated grief. Dialogues Clin Neurosci. 2012 Jun;14(2):177-86.

Wagner, B., Hofmann, L., & Grafiadeli, R. (2021). The relationship between guilt, depression, prolonged grief, and posttraumatic stress symptoms after suicide bereavement. J Clin Psychol, 77, 2545–2558.

988 Lifeline from page 22

As the Chief 988 Lifeline Officer at Vibrant Emotional Health (Vibrant), the nonprofit administrator of the 988 Lifeline, I am proud to lead a dedicated team from diverse professional backgrounds. Each member of our team understands the severity of the mental health crisis in America and the heightened need for mental health support during the winter months.

Through the 988 Lifeline, we tirelessly provide essential resources and assistance to those struggling with Seasonal Affective Disorder. We are continually working to optimize our support services to ensure access and inclusion within the 988 Lifeline to meet the unique needs of at-risk groups, including youth, rural populations, BIPOC communities, and LGBTQI+ individuals.

While the 988 Lifeline remains a vital resource, providing support to millions, raising awareness about SAD, and fostering open, honest dialogue about topics related to mental health are equally important. Vibrant and 988 are important pieces of the crisis care continuum, but the rest of the support network comprises families, friends, and community members.

Tia Dole, PhD

As an increasing number of U.S. adults face mental health challenges, particularly during winter months, I encourage everyone to take the time to connect with others. Reaching out to your community, family members, or friends can significantly reduce stress and positively impact their day, often in ways you may not immediately realize. Engaging in discussions about your feelings, whether positive or negative, helps to destigmatize mental health issues.

Additional effective strategies for managing seasonal stress and SAD include participation in cultural, spiritual, or religious activities, volunteering with a local organization that interests you, and maintaining a healthy diet and lifestyle.

Suicide is a complex issue, yet it can be addressed effectively. In the U.S., for every individual who dies by suicide each year, 280 others experience serious thoughts of suicide but do not act on them. To reduce the number of preventable deaths, the crisis care continuum must evolve better to meet the needs of those in crisis and distress. This includes being prepared for the mental health impacts of the changing seasons and other significant events. If you or someone you know is struggling during the holiday season, text or call 988 or chat online at www.988lifeline.org.

Tia Dole, PhD, (she/her) is the Chief 988 Suicide & Crisis Lifeline Officer at Vibrant Emotional Health. Dr. Dole is a licensed clinical psychologist and a long-time advocate for the rights of those with intersectional identity. Prior to stepping into the role of Chief 988 Officer, Dr. Dole was the Executive Director of The Steve Fund, the nation's only organization focused on the mental health and emotional well-being of young people of color. Additionally, Dr. Dole was the Chief Clinical Operations Officer at The Trevor Project, the world's largest suicide prevention and crisis intervention organization for LGBTQ youth. Dr. Dole oversaw all of The Trevor Project's crisis services programs as well as their volunteer community and increased their impact by a factor of four.

After completing her bachelor's degree at Carleton College, Dr. Dole received her Master's degree in

Developmental Psychopathology from Columbia University (Teacher's College), and she received a Fulbright Fellowship to study Forensic Psychology in Switzerland. She then completed her doctorate in clinical psychology at Fordham University. Dr. Dole is a published author and sits on several committees. One of her passions is normalizing mental health conditions within communities of color, LGBTQ communities, and helping people get access to services. She is based in New York/New Jersey.

Marginalized from page 27

immigrants face acculturation stress, a byproduct of adapting to a new culture, learning a language, and navigating unfamiliar societal norms. Latino immigrants in the United States have reported high levels of acculturation stress, which are strongly associated with depression and suicidal ideation (Fortuna et al., 2008). This adjustment often creates identity conflicts, especially for younger immigrants who straddle the values of their heritage and those of their new environment.

Another often marginalized population is the growing LGBTQ+ community, which continues to face unique and pervasive challenges. At the core of these struggles is societal stigma, which manifests as judgment, prejudice, and outright rejection. For many LGBTQ+ individuals, being part of a minority group often means navigating a world where acceptance is not guaranteed, and support can be hard to find. According to The Trevor Project (2023), nearly 45% of LGBTQ+ youth reported experiencing discrimination based on their sexual orientation or gender identity in the past year alone. These experiences can lead to feelings of shame, fear, and alienation, which are major risk factors for depression and suicidal ideation. Accessing mental health care is often a daunting journey for LGBTQ+ individuals, marked by systemic obstacles and emotional hurdles that can make seeking help feel overwhelming. Imagine finally gathering the courage to share deeply personal struggles, only to face a provider who doesn't understand, or worse, dismisses, your experiences. Unfortunately, this is a reality for many within the LGBTQ+ community.

Intersectionality:
When Disadvantages Overlap

Marginalized individuals often face not just one but multiple layers of disadvantage that compound their struggles. This

Oyindamola Williams, LMSW

concept, known as intersectionality, refers to the overlapping forms of discrimination based on race, gender, sexual orientation, socioeconomic status, and other identities. These intersections create unique challenges that cannot be understood in isolation. Each layer of marginalization amplifies the others, creating barriers that affect every aspect of her life, from accessing healthcare to feeling safe in public spaces. Research shows that individuals with intersecting marginalized identities are at a higher risk for mental health challenges, including depression and suicidal ideation (Meyer, 2015). This overlap complicates solutions. A program designed to address racial disparities in healthcare might not consider the unique needs of LGBTQ+ individuals within that racial group. Similarly, mental health services that cater to LGBTQ+ populations may overlook the specific barriers faced by immigrants or people with disabilities.

Culturally Responsive Approaches

Addressing suicide in marginalized communities requires strategies that reflect the unique cultural and social realities of these groups. Standard approaches often fall short, failing to consider the diverse challenges these populations face. Instead, culturally responsive interventions focus on building trust and delivering care that resonates with individuals' lived experiences. One key strategy is community engagement. Partnering with trusted figures, like faith leaders or community organizers, helps break down stigma and create safe spaces for discussing mental health. For example, African American church programs have successfully increased awareness and access to care by leveraging the influence of faith-based institutions (Hankerson & Weissman, 2022). Another essential element is cultural competence training for providers. Mental health professionals must understand how cultural backgrounds shape expressions of distress and healing. Offering services in multiple languages or training providers in cultural humility can make a significant difference for immigrants and other marginalized groups (Hinton et al., 2012).

Finally, incorporating traditional healing practices, such as storytelling or community circles, bridges gaps in trust and complements evidence-based therapies. These culturally rooted practices not only address mental health but also foster a sense of belonging and identity. Culturally responsive care isn't just about improving access; it's about meeting people where they are and affirming their unique experiences. By prioritizing this approach, we can create more inclusive and effective pathways to mental wellness.

Oyindamola Williams, LMSW, is a Child and Family Therapist at Southwest Community Health Center. For more information and resources, please contact oyinwilliams01@gmail.com.

References

BMC Public Health. (2022). The prevalence of suicidal ideation and behavior among refugees: A systematic review and meta-analysis. BMC Public Health, 22(13029). Retrieved from https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-13029-8

Centers for Disease Control and Prevention. (2023). Suicide data and statistics. Retrieved from https://www.cdc.gov/suicide/facts/data.html

Fortuna, L. R., Porche, M. V., & Alegría, M. (2008). Political violence, psychosocial trauma, and the context of mental health services use among immigrant Latinos in the United States. Ethnicity & Health, 13(5), 435–463. https://doi.org/10.1080/13557850701837286

Hankerson, S. H., & Weissman, M. M. (2022). Church-based programs to reduce stigma and increase access to care for mental illness: A review. Psychiatric Services, 73(6), 711-717. https://doi.org/10.1176/appi.ps.201100216

Hinton, D. E., Pich, V., Hofmann, S. G., & Otto, M. W. (2012). Cultural adaptations of cognitive-behavioral therapy: Current findings and directions for future research. Behavior Therapy, 43(3), 431-447. https://doi.org/10.1016/j.psc.2017.08.006

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. Psychology of Sexual Orientation and Gender Diversity, 2(3), 209-213. https://doi.org/10.1037/sgd0000132

The Trevor Project. (2023). 2023 National Survey on LGBTQ Youth Mental Health. Retrieved from https://www.thetrevorproject.org

World Health Organization. (2021). Suicide worldwide in 2019: global health estimates.

Social Media from page 25

Recognizing Warning Signs

Over time, however, Emma's relationship with social media began to shift. She spent hours scrolling, comparing herself to influencers and peers whose lives seemed impossibly polished. These comparisons started to weigh heavily on her self-esteem, leaving her feeling inadequate. She became withdrawn, her grades dropped, and she frequently complained of fatigue and headaches.

Parents and family members might struggle to identify when their child's social media use has become harmful, as changes in behavior can often be subtle. Behavioral changes can include social withdrawal, increased irritability, and changes in sleep or eating patterns. Additional warning signs include changes in mood or reports of hopelessness. These warning signs have been found in children who had been experiencing cyberbullying or were engaging in self-harm online content (John et al., 2018). Additionally, notable academic declines or frequent absence and risk-taking behavior, such as engaging in self-harm or substance use, may be a result of underlying mental health issues (Cataldo et al., 2021). Families should recognize that with children, physical complaints such as unexplained fatigue, headaches, or stomachaches, which have no clear medical cause, can suggest emotional distress as well.

Social Media,
Suicidality, and Self-Harm

Her parents grew concerned when Emma started avoiding social interactions and became irritable. Their alarm peaked when her mother discovered scratches on Emma's forearm, which Emma admitted were from self-harm. She explained that seeing others' seemingly perfect lives on social media made her feel hopeless - like she could never measure up.

The link between social media use and increased risk of suicidality and self-harm among adolescents has been a growing concern. Research suggests that exposure to harmful online content, such as the promotion of self-harm, suicide, and other dangerous behaviors, can normalize these actions for vulnerable youth (Marchant et al., 2017). Social media can also become a vehicle for cyberbullying or online harassment, exacerbating feelings of self-isolation and worthlessness for a child who may already be struggling with depression, leading to suicidal ideation and self-harm (Livingstone et al., 2014; Twenge et al., 2019). Algorithms continue amplification of emotionally charged or harmful content, creating a cycle of exposure and distressing material (Nesi, 2020).

How Families Can Help

Families play a vital role and are the first line of defense in helping break this vicious cycle by fostering open communication and monitoring their children's social media activity. Parents and caregivers must remain vigilant of their child's online environment, engaging in open conversations about what content they are seeing and experiencing online. By recognizing early warning signs early, parents can prevent further escalation. The U.S. Surgeon General Advisory provides the following recommendations:

Abraham Abdulrazzak, DO

- Establish clear rules about screen time and create tech-free zones, such as during meals or before bedtime, to encourage in-person interactions.
- Demonstrate responsible social media use by limiting your own screen time and prioritizing face-to-face connections.
- Teach children to recognize harmful online content, practice critical thinking, and seek help when they feel distressed.
- Regularly talk with your child about their online experiences and monitor social media activity for signs of harmful interactions or excessive use.

The American Academy of Child and Adolescent Psychiatry (AACAP) provides the following guidelines for screen time:

- **Ages 18 to 24 months:** Limit screen time to high-quality educational programming and always engage with a caregiver during viewing.
- **Ages 2 to 5 years:** Restrict non-educational screen time to no more than one hour per weekday and up to four hours on weekend days.
- **Ages 6 years and older:** Encourage healthy habits, establish clear boundaries, and limit screen time to ensure it does not interfere with sleep, physical activity, or face-to-face interactions.

When to Seek Help and the Role
of Therapists and Psychiatrists

Emma's parents sought help from a child psychiatrist, who diagnosed her with major depressive disorder, exacerbated by excessive and problematic social media use. Her treatment plan included cognitive-behavioral therapy (CBT) to help her identify and challenge negative thought patterns, develop healthier coping strategies, and reframe her self-perception. To further support her mood, the psychiatrist started her on a low-dose selective serotonin reuptake inhibitor (SSRI), explaining that medication could help alleviate the more persistent depressive symptoms while therapy took effect.

The psychiatrist also recommended practical lifestyle changes, including setting limits on her screen time, enrolling in offline activities like a local photography club, and establishing structured daily routines to foster stability. With a combination of therapy, medication, and family support, Emma began to see gradual improvements. She became more engaged in school, reconnected with friends, and found joy again in photography.

Samuel Jackson, MD

While families are instrumental in providing initial support, sometimes professional help is necessary. Parents should consider reaching out to a mental health professional if their child exhibits persistent signs of emotional distress, such as:

- **Hopelessness or suicidal thoughts:** Frequent expressions of despair, lack of purpose, or discussions about self-harm or wanting to die.
- **Self-harming behaviors or preoccupation with harmful content:** Recurrent self-injury or fixation on disturbing or triggering material online.
- **Severe mood swings or withdrawal:** Persistent irritability, emotional outbursts, isolation from friends and family, or loss of interest in activities they once enjoyed.
- **Unexplained physical complaints:** Ongoing fatigue, headaches, or other physical symptoms without a medical explanation, which may indicate underlying emotional distress.
- **Academic or behavioral changes:** Significant drops in academic performance, skipping school, or engaging in risky or impulsive behaviors, such as experimenting with substances or engaging in unsafe online activities.

Families are uniquely positioned to protect their children from the potential harms of social media by fostering open communication, modeling healthy online behaviors, and setting clear boundaries around technology use. By staying engaged, recognizing warning signs, and seeking professional help when necessary, parents and caregivers can create a supportive environment that promotes resilience and prioritizes their child's mental health in an increasingly digital world.

Abraham Abdulrazzak, DO, is a Resident Psychiatrist at SUNY Downstate Health Sciences University and a Fellow with the Brooklyn LEND (Leadership Education in Neurodevelopmental Disabilities) program at SUNY Downstate. Samuel Jackson, MD, serves as the Clinical Director of Psychiatry at Erie Family Health and Co-Director of Public Psychiatry Education at SUNY Downstate Health Sciences University. For more information, email abraham.abdulrazzak@downstate.edu or samuel.wesley.jackson@gmail.com.

References

American Academy of Child and Adolescent Psychiatry. (2024). Children and watching TV. AACAP. Retrieved December 8, 2024, from https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Children-And-Watching-TV-054.aspx

Cataldo, I., Lepri, B., Neoh, M. J. Y., & Esposito, G. (2021). Social Media Usage and Development of Psychiatric Disorders in Childhood and Adolescence: A Review. Frontiers in psychiatry, 11, 508595. https://doi.org/10.3389/fpsyt.2020.508595

John, A., Glendenning, A. C., Marchant, A., Montgomery, P., Stewart, A., Wood, S., Lloyd, K., & Hawton, K. (2018). Self-Harm, Suicidal Behaviours, and Cyberbullying in Children and Young People: Systematic Review. *Journal of medical Internet research*, *20*(4), e129. https://doi.org/10.2196/jmir.9044

Livingstone, S., & Smith, P. K. (2014). Annual research review: Harms experienced by child users of online and mobile technologies: the nature, prevalence, and management of sexual and aggressive risks in the digital age. Journal of child psychology and psychiatry, and allied disciplines, 55(6), 635–654. https://doi.org/10.1111/jcpp.12197

Logrieco, G., Marchili, M. R., Roversi, M., & Villani, A. (2021). The Paradox of TikTok Anti-Pro-Anorexia Videos: How Social Media Can Promote Non-Suicidal Self-Injury and Anorexia. International journal of environmental research and public health, 18(3), 1041. https://doi.org/10.3390/ijerph18031041

Marchant, A., Hawton, K., Stewart, A., Montgomery, P., Singaravelu, V., Lloyd, K., Purdy, N., Daine, K., & John, A. (2017). A systematic review of the relationship between internet use, self-harm, and suicidal behavior in young people: The good, the bad and the unknown. PloS one, 12(8), e0181722. https://doi.org/10.1371/journal.pone.0181722

Nesi, J., & Prinstein, M. J. (2015). Using Social Media for Social Comparison and Feedback-Seeking: Gender and Popularity Moderate Associations with Depressive Symptoms. *Journal of abnormal child psychology*, *43*(8), 1427–1438. https://doi.org/10.1007/s10802-015-0020-0

Nesi J. (2020). The Impact of Social Media on Youth Mental Health: Challenges and Opportunities. North Carolina medical journal, 81(2), 116–121. doi.org/10.18043/ncm.81.2.116

Twenge, J. M., Cooper, A. B., Joiner, T. E., Duffy, M. E., & Binau, S. G. (2019). Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005-2017. Journal of abnormal psychology, 128(3), 185–199. https://doi.org/10.1037/abn0000410

Zubair, U., Khan, M. K., & Albashari, M. (2023). Link between excessive social media use and psychiatric disorders. Annals of medicine and surgery (2012), 85(4), 875–878. https://doi.org/10.1097/MS9.0000000000000112

Survivor's Guilt from page 24

of guilt and allowing space for healing.

As Maya Angelou once said, "We can not change the past, but we can change our attitude toward it. Uproot guilt and plant forgiveness."

Coping with Survivor's Guilt is not one-size-fits-all. Take it one day at a time and let yourself feel the pain; that means it's okay to cry. It's normal to even feel angry at the person who committed suicide. And it's okay to express it. (Bolton, n.d.)

Self-forgiveness and compassion will become your healing duo. Exercises like writing compassionate letters to oneself or practicing positive self-talk are great starting points when you're ready. Additionally, connecting with others who have been impacted by the same loss can provide significant emotional support. Sharing experiences with those who understand the complexity of Survivor's Guilt fosters a sense of community and can alleviate the feeling of isolation. This can also be done through support groups.

When you find yourself revisiting those "what ifs," it's okay not to have all the answers. Sometimes, the path to healing involves accepting that complete understanding may never come. Over time, you may find peace in the partial answers. It's a gradual process, but allowing yourself the space to let go of the need for certainty can bring a sense of relief and help you move forward with greater emotional balance. (Feigelman, Gorman, & Jordan, 2015)

Lorna Wittenrich, MA, QS, LMHC

Post-traumatic growth is possible, and the most important solution to Survivor's Guilt is moving forward. It's imperative that we find meaning in our continued living. For some, this could mean creating a lasting legacy, whether through writing, artistic expression, or sharing personal stories. Others may find meaning in actively participating in suicide prevention efforts.

It never hurts to seek professional help. Survivor's Guilt is a type of complicated grief that is often far beyond anyone's normal understanding. Speaking to a licensed professional is a helpful way to truly break down your feelings and uncover and understand the root causes of your guilt.

As suicide rates continue to increase, those affected by suicide will follow suit. To prevent further tragedy, individuals must embrace self-forgiveness, seek support, and gradually shift focus from the "what ifs" to a healthier perspective. Remember, you are not alone in this experience, and with time and compassion, it is possible to emerge stronger and more resilient. Healing is a process, and every small step toward understanding and acceptance is progress.

Lorna Wittenrich, MA, QS, LMHC, is Director of Clinical Services at Dupont Counseling Group. Dupont Counseling Group, a division of The LJD Jewish Family & Community Services (JFCS), provides trusted mental health services in Jacksonville, FL. With more than 70 years of combined experience, its team of professional mental health counselors, marriage/family therapists, and clinical social workers offers individual, family, and couples counseling for children, adults, and seniors. For more information, visit Jacksonville-Counseling.org.

Sources

American Foundation for Suicide Prevention. (n.d.). Suicide statistics. Retrieved from https://afsp.org/suicide-statistics/

Bolton, I. (n.d.). Beyond surviving: Suggestions for survivors.

Centers for Disease Control and Prevention. (n.d.). Mental health: Suicide prevention. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC7190787/#B1

Feigelman, W., Gorman, B. S., & Jordan, J. R. (2015). Stigmatization and suicide bereavement. Social Sciences, 4(3), 688–705. https://www.mdpi.com/2076-0760/4/3/688

Grief from page 25

survivors are at increased for suicidal behaviors (Jordan & McMenamy, 2004).

Jordan (2001) argued that suicide bereavement was fundamentally different from mourning other deaths. Citing numerous sources, Jordan claimed a consensus of clinicians that "the mourning process after suicide is different and more difficult than mourning other types of deaths" (p.91). In other words, the more difficult bereavement for a death by suicide can easily lead to prolonged grief, which greatly increases the risk of suicide for suicide survivors that are already at higher risk.

In the DSM-IV -TR (American Psychiatric Association, 2000), the only mention of bereavement is a paragraph under Other Conditions that may be a Focus of Clinical Attention. Prior to the recognition of complicated or prolonged grief, it was suggested here that the focus of clinical attention should be on a diagnosis of major depressive disorder, but the diagnosis is "generally not given unless the symptoms are still present 2 months after the loss" (p. 741) this is a much shorter time period than what was eventually chosen for diagnosis of prolonged grief (12 months). When the World Health Organization added prolonged grief disorder to the ICD-11, they used a timeline of six months (Weir, 2018). Prigerson et al. (1999), again making the case for a distinct diagnosis for traumatic grief (having chosen traumatic grief over complicated grief as used in 1995 articles), argued that simply treating for depression ignored the growing evidence that "the symptoms of traumatic grief form a factor that is separate from symptoms of depression and anxiety" (p. 67). As for clinical implications, they claimed: "precise definition of traumatic grief will lead to the development of more specific treatments" (p. 72).

Indeed, by 2024, Rosner et al. (2024) were comparing prolonged grief-specific cognitive behavioral therapy (PG-CBT) to present-centered therapy (PCT). They found that PG-CBT was superior to PCT both after treatment and at follow-up. They described PG-CBT as "focused on the exposure to the worst moment of the loss and cognitive restructuring of grief-related cognitions in combination with solution-focused and experiential methods" (p. E1). For an example of an experiential method, they cited walking to the grave. These methods suggest exposure methods as used for treating PTSD, which is listed as a differential diagnosis for prolonged grief but which is also frequently comorbid. Bryant et al. (2024) found grief-focused CBT to show better results than mindfulness-based cognitive therapy. Bryant set out to show mindfulness-based therapy could be a viable alternative to PG-CBT but found PG-CBT showed better results, both post-treatment and at follow-up, for depression and grief-related cognition.

Thus, evidence is accumulating for best practices addressing prolonged grief. We are also seeing evidence of neuropsychological abnormalities in complicated grief. Functional MRIs have detected alterations in the reward system. Those experiencing prolonged grief show more activity in the reward center than those experiencing depression. It appears the yearning for the deceased is maintaining a connection that is still rewarding (Weir, 2018). Disturbances are also noted in emotional regulation and neurocognitive functioning. There also appears to be a greater likelihood for other health problems such as sleep disturbances, substance use, cardiovascular disease, immune system issues, and more. (Shear, 2015).

Thomas Grinley, MS, MBA, CMQ/OE, LSSGB, CCISM

Despite the continuing controversy over its inclusion in the DSM, we must at least consider the possibility, if not likelihood, of the existence of prolonged grief and its meaning for suicide survivors. Once we accept that, we will have a good idea of what issues to watch for, and we will have proven therapy for treatment. It has been shown it is more than just depression, and treatments for depression do not work.

Thomas Grinley, MS, MBA, CMQ/OE, LSSGB, CCISM, is Health Services Evaluation Planning and Review Specialist of Bureau of Program Quality - Health Services Assessment Unit at NH Department of Health and Human Services.

References

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.)

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.)

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.)

Bryant, R. A., Azevedo, S., Yadav, S., Cahill, C., Kenny, L., Maccallum, F., ... & Dawson, K. S. (2024). Cognitive Behavior Therapy vs Mindfulness in Treatment of Prolonged Grief Disorder: A Randomized Clinical Trial. *JAMA psychiatry*.

Eisma, M. C. (2023). Prolonged grief disorder in ICD-11 and DSM-5-TR: Challenges and controversies. *Australian & New Zealand Journal of Psychiatry*, *57*(7), 944-951.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and life-threatening behavior*, *31*(1), 91-102.

Jordan, J. R., & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and life-threatening behavior*, *34*(4), 337-349.

Moore, M. M., & Freeman, S. J. (1995). Counseling survivors of suicide: Implications for group postvention. *Journal for Specialists in Group Work*, *20*(1), 40-47.

Prigerson, H. G., Maciejewski, P. K., Reynolds III, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., ... & Miller, M. (1995). Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. *Psychiatry research*, *59*(1-2), 65-79.

Prigerson, H. G., Frank, E., Kasl, S. V., Reynolds, C. F., Anderson, B., Zubenko, G. S., ... & Kupfer, D. J. (1995). Complicated grief and bereavement-related depression as distinct disorders: preliminary empirical validation in elderly bereaved spouses. *American journal of Psychiatry*, *152*(1), 22-30.

Prigerson, H. G., Shear, M. K., Jacobs, S. C., Reynolds, C. F., Maciejewski, P. K., Davidson, J. R., ... & Zisook, S. (1999). Consensus criteria for traumatic grief: A preliminary empirical test. *The British journal of psychiatry*, *174*(1), 67-73.

Rosner, R., Rau, J., Kersting, A., Rief, W., Steil, R., Rummel, A. M., ... & Comtesse, H. (2024). Grief-Specific Cognitive Behavioral Therapy vs Present-Centered Therapy: A Randomized Clinical Trial. *JAMA psychiatry*.

see Grief on page 39

Key Insights from page 26

can administer the Columbia-Suicide Severity Rating Scale (C-SSRS) to evaluate patients for early signs of risk. Hence the reason early detection contributes to minimized instances of improper efforts at committing suicide. A 2023 study published in the National Library of Medicine determined that incorporating a screening process into emergency care decreased SUD patients' suicide rates by 30%.

Integrated Treatment Models - Another model of treatment is an integrated treatment where both SUD and mental health disorders are treated at the same time. This model integrates CBT, pharmacotherapy, and supportive interventions. Thus, the patients will receive a holistic treatment. Integrated care is also effective in the prevention of suicidal behavior, having been recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) to reduce risks by 25% due to the treatment of the related mental illness to substance use.

Cognitive Behavioral Therapy or (CBT) - The utilization of CBT is widespread for reducing suicidal thoughts in those with SUDs. It teaches patients to recognize and change how they think and cope. According to the American Psychological Association (APA), CBT has been proven to reduce up to 50 percent of suicidal ideation, especially if substance misuse treatment is added to CBT.

Crisis Intervention and Support Services - The 988 Suicide & Crisis Lifeline, a crisis helpline, reaches out to people in crisis. Counseling, local mental health resource referral, and de-escalation of crises are the services these offer. Utilizing such services in such a way to expand their availability and accessibility will help reduce the rates of suicide among people with SUDs.

Medication Assisted Treatment (MAT) - Based on FDA-approved medications and counseling, MAT successfully reduces cravings and withdrawal symptoms, keeps patients stable, and reduces suicide risk. A low dose of approved drugs, such as buprenorphine and naltrexone, can minimize opioid dependency and lead to less production of the local chemical known to

Temitope Fabayo, BA, MBA

cause suicide attempts – dopamine. A report produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) notes that MAT programs can decrease opioid-induced suicides by up to 60 percent.

Community and Policy-level interventions

Peer Support and Recovery Community - Peer support programs are vital to the community and address social isolation. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are organizations providing a setting where people tell their stories and give mutual encouragement. There have been studies that demonstrate that peer support groups result in favorable mental health outcomes and decreased suicidal ideation.

Public Awareness Campaigns - Reducing stigma against SUDs and mental health is an important educational campaign. More people will get help and support when they increase public awareness. A study states that Community-based education programs focused on recognizing and treating suicide and substance misuse earlier in the community can reduce rates of suicide by more than 50%, according to the WHO.

Policy Reforms - As mentioned by governments, more access to mental health and addiction treatment services needs to be guaranteed. The research into the SUD-suicide link needs funding and concrete legislation that limits access to harmful substances that have long-lasting effects. The Centers for Disease Control and Prevention (CDC) supports comprehensive preventive care policies and immediate intervention strategies.

How Families and Friends Can Help

Families and friends are central to the lives of persons with SUDs and suicidal ideation and are part of the recovery process. That is how they may help.

Recognize Warning Signs - Note any behavior change, such as loss of interest in daily activities, bad temper, or feeling of helplessness. Getting an early diagnosis will mean early treatment.

Thumb The Treatment and Support - Promote professional assistance, make appointments with them, and assist in complying with prescribed regimens.

Limit Exposure to Toxic Products - Protect settings by restricting the availability of alcohol, drugs, or any other form of harm.

Stay Involved - Engaging in recovery, not only by going to family therapy sessions or support meetings, will enhance the patient's commitment to change.

Foster a Positive Environment - Practice healthy lifestyle habits, leisure activities, and the overall regimen to discourage relapse while at the same time discouraging suicidal thoughts.

Conclusion

Combating the dual phenomenon of Substance Use Disorders and suicide is a community endeavor. Healthcare providers and policymakers perform some of these roles, but the real mobility support mainly comes from families and friends. When it comes to mental health, they make a difference by identifying potential indications of developing a mental illness, showing encouragement as well as getting involved in treatment. As a society, we can work to combat the stigma, offer hope, and use the tools needed to help people make the necessary changes to save their lives and lead happier, healthier lives.

Temitope Fabayo, BA, MBA, is President of DMC HomeCare.

References

Dillon, E. C., Huang, Q., Deng, S., Li, M., Ernell de Vera, Pesa, J., Nguyen, T. H., Kiger, A. J., Becker, D. F., & Kristen M.J. Azar. (2023). Implementing universal suicide screening in a large healthcare system's hospitals: rates of screening, suicide risk, and documentation of subsequent psychiatric care. *Translational Behavioral Medicine*. doi.org/10.1093/tbm/ibac117

How many people die by suicide in the United States each year? | USAFacts. (2022). Usafacts.org. usafacts.org/answers/how-many-people-die-by-suicide/country/united-states/

Medication-Assisted Treatment Improves Outcomes for Patients With Opioid Use Disorder. (2016, November 22). Pewtrusts.org. www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

Smith, R., Lavalley, C. A., Taylor, S., Stewart, J. L., Khalsa, S. S., Berg, H., Ironside, M., Paulus, M. P., & Aupperle, R. (2023). Elevated decision uncertainty and reduced avoidance drives in depression, anxiety and substance use disorders during approach–avoidance conflict: a replication study. *Journal of Psychiatry & Neuroscience*, *48*(3), E217–E231. doi.org/10.1503/jpn.220226

Stringer, H. (2024, January 1). *Psychologists are innovating to tackle substance use by building new alliances in treatment efforts*. Apa.org. www.apa.org/monitor/2024/01/trends-psychologists-tackling-substance-use

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION 2021 Report to Congress on the State Opioid Response Grants (SOR) Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. (n.d.). www.samhsa.gov/sites/default/files/2021-state-opioid-response-grants-report.pdf

US Department of Health and Human Services. (2024). *Community-Based Suicide Prevention*. www.ncbi.nlm.nih.gov; US Department of Health and Human Services. www.ncbi.nlm.nih.gov/books/NBK604170/

Stabilization Center from page 12

to recovery and wellness. Collaborating with Dutchess County, we have redefined compassionate and effective care for those in crisis. We are thrilled to receive this prestigious certification, affirming our dedication to serving the mental health needs of our community."

Since its inception, Dutchess County's Stabilization Center has served as a vital resource for individuals experiencing mental health crises, providing immediate access to crisis assessment, stabilization, and referral services. The facility's multidisciplinary approach, which integrates peer support, counseling, and linkages to community resources, has been instrumental in promoting recovery and reducing the burden on emergency departments and law enforcement agencies.

This latest achievement, receiving New York's first license to operate a facility of this type, is a testament to the dedication and hard work of our staff, partners, and the larger community. It reaffirms our commitment to providing timely, compassionate, and effective crisis intervention services to individuals facing mental health challenges."

New York State's licensing process, overseen by NYS OMH and OASAS, involved rigorous assessments of the Stabilization Center's infrastructure, services, and adherence to best practices in crisis intervention and mental health care. The Stabilization Center met and exceeded stringent criteria, including staffing qualifications, service accessibility, collaboration with community resources and adherence to evidence-based practices.

New York defines a Supportive Crisis Stabilization Center (SCSC) as a center that provides support and assistance to individuals with mental health and/or substance use crisis symptoms. Such centers provide services for individuals experiencing challenges in daily life who do not pose a likelihood of serious harm. SCSCs will provide voluntary services, with an emphasis on peer support that is resilience and recovery-oriented; these facilities also provide behavioral health support 24 hours per day, seven days per week. Recipients may receive services in a SCSC for up to 24 hours.

People USA's mission is to educate, support, and empower people and communities to understand, manage, and overcome mental health, addiction, and social determinants of health challenges. Their programs are proven to significantly reduce hospital utilization, incarceration rates, and overall healthcare spending. Because of its success, People USA's program models have been studied and replicated across the United States and Europe. Government agencies and community organizations can receive consultation services directly from CEO Steve Miccio, the visionary behind the organization's innovative approach. To learn more, for consultation, or to support this work, visit people-usa.org.

Technology and AI from page 23

support systems enabled providers to choose treatments that were both effective and well-tolerated: Clinicians delivered the right treatment the first time nearly 70% of the time, doubling the industry average.

In addition to treatment accuracy, AI holds the potential to help identify suicide risk factors early. Large language models can be deployed to analyze patient language in real-time, recognizing subtle warning signs that might otherwise go unnoticed in routine care. Serving appropriate alerts to clinicians can improve the time to intervention and potentially save lives.

Generative AI can work alongside structured data analysis by reviewing unstructured patient language, such as free text, to identify potential red flags, such as hopelessness or other risk factors of suicide. Research published in JMIR Mental Health showed that AI tools like OpenAI's GPT-4 were able to identify and predict a mental health crisis (endorsement of suicidal ideation with a plan) with similar accuracy but higher sensitivity and lower specificity than senior trained psychiatrists and psychologists.

Mimi Winsberg, MD

AI can also improve how clinicians track high-risk patients between appointments. Remote monitoring enables continuous risk assessment, ensuring that changes in a patient's condition are flagged and addressed in a timely fashion.

Beyond clinical advancements, AI enhances the clinician-patient dynamic by alleviating administrative burdens. Automated tools for tasks like medical note generation, therapy transcript analysis, chart summaries, and quality assessments free up clinicians to spend more time on meaningful interactions with their patients. By improving efficiency, AI creates a more supportive and personalized care experience for both providers and patients.

The Path Forward: Collaboration and Innovation in Mental Health Care

The suicide crisis demands more than traditional approaches—it calls for innovation, collaboration, and the integration of technology to save lives. By leveraging telehealth and AI, we can create care models that are proactive, personalized, and accessible, addressing the urgent needs of individuals at risk—not only for those experiencing suicidal ideation but also underserved populations like those with substance use disorder, teenagers, and their caregivers, and Medicaid and Medicare beneficiaries.

These tools not only enhance diagnostic accuracy and real-time intervention but also strengthen the clinician-patient relationship. As we continue to refine and expand these technologies, we have an opportunity to reimagine mental health care, ensuring that no one faces a crisis alone.

Mimi Winsberg, MD, is a Stanford-trained psychiatrist who brings over 30 years of clinical experience to her role at Brightside Health, which delivers life-saving mental health care to people with mild to severe clinical depression, anxiety, and other mood disorders, as well as substance use disorder. As Chief Medical Officer and Co-Founder, she leads Brightside Health's psychiatry and therapy clinical programs, with a focus on optimizing patient engagement and outcomes, and contributes to peer-reviewed research. Previously, Dr. Winsberg applied her clinical skills in leadership roles at Ginger and Lyra, as well as serving as the on-site psychiatrist at the Facebook Wellness Center. She holds a B.A. in Neuroscience from Harvard College; is on the leadership council of Brainstorm, the Stanford Laboratory for Brain Health Innovation and Entrepreneurship; is the author of the book Speaking In Thumbs (Doubleday, 2022); and regularly speaks at events across the country.

Saving Lives from page 1

OMH is also sponsoring community-based programs, such as CARES UP, a prevention effort aimed at fostering and supporting the mental health and well-being of military veterans and our first responders. Recipient organizations use the funding to promote resiliency, suicide prevention, and peer work to establish a culture of wellness.

With the first round of funding distributed last year, the initiative provided grants to 15 agencies to enhance their suicide prevention efforts and wellness programs for these individuals who are more often exposed to and often face higher rates of trauma. This year, funding for CARES UP was doubled, allowing the Suicide Prevention Center to expand the program.

It is often unrecognized that individuals in the construction industry have one of the highest rates of suicide in New York. The Suicide Prevention Center has a pilot program aimed at increasing mental wellness among construction industry workers in the Capital Region. Launched in September, the Building Hope Through Action program is aimed at decreasing suicides in this population while integrating mental wellness and suicide prevention into the construction trade's organizational culture.

This fall, the Suicide Prevention Center also began the 'MISSION' project to help at-risk youth and young adults on Staten Island through prevention and clinical intervention. The project will integrate prevention services into local public schools in the borough, Wagner College, and the College of Staten Island, which is part of the City University of New York system, along with four major behavioral health organizations serving the area.

This initiative also strengthens behavioral health support on Staten Island, including training for adults to identify and refer at-risk youth to an integrated system for rapid referrals and providing universal screening and evidence-based interventions in behavioral health settings. Over five years, the project is expected to provide prevention services to more than 30,000 youth and young adults between the ages of 10 and 24 who are at risk for suicide, with an additional 12,000 youth being provided clinical services.

Likewise, we are helping community-based service providers to develop innovative programs that will help reduce suicide risk among youth from historically underserved populations. Funding through the Connecting Youth to Mental Health Supports program is helping to develop programs and suicide prevention strategies among racial and ethnic minority populations and LGBTQ+ groups, including those in rural areas.

We reconvened the New York State Suicide Prevention Task Force with a renewed focus on helping at-risk populations, such as communities of color disproportionally impacted by suicide or suicidal ideation. Established in partnership with the Suicide Prevention Center, the Task Force will build on existing prevention efforts and explore the mental health challenges laid bare during the COVID-19 pandemic.

In addition, we need to assist those New Yorkers on the brink of a behavioral health crisis, which is where the New York State 988 Suicide and Crisis Lifeline comes in. Launched in July 2022, 988 provides an easy-to-remember, three-digit number to access mental health services supported in all 62 counties of the state and provides a connection to trained crisis counselors who can help anyone in crisis or emotional distress. The service is free, confidential, impartial, and can be accessed 24 hours a day and seven days per week by calling or texting "988" or visiting 988.ny.gov.

To help increase public awareness of 988, we launched 'We Hear You,' a multi-year public awareness campaign that is aimed at helping more New Yorkers recognize and use this critical service whenever they or someone they know is experiencing a mental health or substance use crisis. You may have recently seen some of our 988 advertisements, which are featured on billboards, on college campuses, during sporting events, on traditional television and radio, and on other digital platforms, such as streaming music and video services.

As part of a new law signed by Governor Kathy Hochul, we will be working with colleges across New York State to ensure information about 988 is printed on all student IDs next year or through other means if their institution doesn't issue these cards. Colleges must also provide students with resources detailing when to utilize 988.

Suicide is an extremely complex issue, and effective prevention measures require cooperation and coordination among all segments of society. OMH is committed to continuing to expand upon our suicide prevention efforts while providing hope, especially to those who are most at risk.

We are implementing new and innovative programs using best practices that are making a difference. Our goal is to ensure that every New Yorker has access to the resources and mental health services they need whenever they may need them.

Dr. Ann M. Sullivan, MD, is Commissioner of the NYS Office of Mental Health (OMH).

Older Adults from page 15

Advocacy for GLBT Elders and as Director of Alzheimer's Programs at the Cobble Hill Health Center. Catherine has published in the areas of Dementia and Long-term care and LGBT Aging and has sat on the New York State Caregiving Coalition, AARP's Caregiving Committee, and the American Society on Aging's LGBT Aging Network. She has served as Adjunct Faculty at the Silberman School of Social Work at Hunter College since 2016. She received her Masters of Social Work from Hunter College School of Social Work.

Visit www.spop.org to learn more about Service Program for Older People (SPOP) and its work as a community-based behavioral healthcare provider for older adults in New York City.

Grief from page 37

Ruocco, K.A., Stumpf Patton, C., Burditt, K., Carroll, B., & Mabe, M. (2022) TAPS Suicide Postvention Model [TM]: A comprehensive framework of healing and growth, Death Studies, 46:8, 1897-1908, DOI: 10.1080/07481187.2020.1866241

Shear, M. K. (2015). Complicated grief. *New England Journal of Medicine*, *372*(2), 153-160.

Szuhany, K. L., Malgaroli, M., Miron, C. D., & Simon, N. M. (2021). Prolonged grief disorder: Course, diagnosis, assessment, and treatment. *Focus*, *19*(2), 161-172.

Weir, K. (2018, November 1). New paths for people with prolonged grief disorder. *Monitor on Psychology*, *49*(10). https://www.apa.org/monitor/2018/11/ce-corner

Zagorski, N. (2020). Nature, Nurture Both Contribute to Suicide Risk. Psychiatric News, 55(19). https://doi.org/10.1176/appi.pn.2020.10a5