Suicide Prevention and Social Determinants of Health

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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. To ask a question during the question and answer session, please press star then 1 on your touchtone phone.

Today's conference is being recorded. If you have any objections, you may disconnect.

Now I'd like to turn the meeting over to Ms. Michelle Hicks. Ma'am, you may begin.

Michelle Hicks: Thank you. Hello and welcome to the training teleconference Suicide Prevention and the Role of Social Determinants of Health. This virtual training session is sponsored by the SAMHSA Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health, also known as the SAMHSA ADS Center. If you would like to reach us, you will find our contact information listed on Slide number 2.

The presentation today will take place during the first hour and will by a 30 minute question and answer session. At the end of the speaker presentation, you may submit a question by pressing star 1 on your telephone keypad.

You will enter a queue and be allowed to ask your question in the order in which it was received. On hearing the conference operator announce your name, please proceed with your question. After you've asked your question your line will be muted. The presenters will then have the opportunity to respond. These instructions are repeated on Slide number 4.

If we do not get to your question today, please feel free to email the ADS Center or any of the presenters following today's call.

Within 24 hours of this teleconference, you will receive an email request to participate in a short anonymous online survey about today's training. Survey results will be used to determine what resources and topic areas need to be addressed by future training events. The survey will take approximately five minutes to complete.
Before we begin, please let me say that the views expressed in this training event do not necessarily represent the views, policies and positions of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration or the U.S. Department of Health and Human Services.

The presenters for our training today are Anara Guard, Heidi Bryan and Diana Morales.

Anara Guard is the Deputy Director for the National Suicide Prevention Resource Center, which is funded by the Substance Abuse and Mental Health Services Administration. In this capacity she manages Resource Center functions, provides communications assistance to SAMHSA funded youth suicide prevention grantees and oversees all grantee technical assistance. Anara has a Master's degree in library and information science and a certificate in maternal and child health.

Our next presenter for today is Heidi Bryan. She is the founder and director of Feeling Blue Suicide Prevention Council, a nonprofit suicide prevention, education and support organization for Pennsylvania. Heidi has battled with depression most of her life, is a suicide attempt survivor and lost her brother to suicide in 1995.

Heidi was the Vice Chairman of the Board of Directors for SPAN U.S.A. and recipient of the Sandy Martin Grassroots Award in 2005. Ms. Bryan is a certified QPR Gatekeeper and Master Trainer, a Provisional Assist Trainer, Co-facilitator of a survivor suicide support group and Co-Chairman of Pennsylvania's Adult and Older Adult Suicide Prevention Coalition.

Through Heidi's efforts, Pennsylvania adopted a suicide prevention week resolution that coincides with the National Suicide Prevention Week. Ms. Bryan received her bachelor's degree in chemistry from Cedar Crest College.

Our final presenter will be Diana Morales, the Vice President of Public Education for Mental Health America. Ms. Morales joined Mental Health America in May 2006 as Vice President of Public Education.

Diana has nearly two decades of experience in developing and managing health promotion programs. She is responsible for the strategic direction and oversight of the organization's national efforts to promote mental wellness.

Key MHA educational programs that she oversees includes Live Your Life Well from Campaign for America's Mental Health featuring proven tools for protecting mental health and improving well being, Dialogue for Recovery designed to enhance recovery and quality of life for people with mental health problems, FundaMENTAL Health Bottomline Sense, addressing the impact of mental health conditions on the U.S. workforce and mpower, Musicians for Mental Health meant to engage youth about mental health and stigma reduction.

We will now hear from our first presenter, Anara Guard.
Anara Guard: Thank you very much. My role today is to bring a public health perspective to the conversation and I'll be particularly focusing on the economic crisis and how that is affecting suicide and suicide prevention.

As I think we have all seen, the economic crisis is very multifaceted. It involves layoffs and unemployment, foreclosures, businesses closing, many bankruptcies at personal and business levels and people losing their investments and retirement savings. And all of this is causing real losses. Not only the loss of employment but of status, of role, of health and mental health benefits that are tied to employment, of home and even as a community as we've known it. If we walk down the street and see all those shuttered businesses or the homes, the for sale signs in front of them, it's affecting all of us whether or not we are immediately affected by a financial crisis ourselves.

So what people have been asking us over the last few months increasingly is "is the economic downturn causing suicide"? Is this an economic disaster that will affect people like other mass natural disasters have? And if either of these are true, what can we do about it? How can we place buffers in the system? How can we better identify people who are in distress, refer them appropriately and increase resiliency in individuals and in communities?

At SPRC we did a literature search trying to see what research and studies have told us about how unemployment and financial crises but affect suicide. And we found many cases that showed that economic downturn and unemployment can be associated with increased rates of suicide and sometimes with increased rates of suicide attempts. But - I have but in there in big red letters, because of the complex picture many individuals who have risk factors for suicide also tend to be unemployed because of those risk factors.

And we'll talk more about those in a minute, but they include things like mental illness, incarceration, problems with drugs and alcohol. All of those lead people to be unemployed and also lead them to be at higher risk for suicide.

Having existing mental illness confounds the results and studies also found that the condition of becoming unemployed is bad for your overall health. So we know that economic turmoil can result in negative health effects, both physical and mental, some of this can be due to increased stress but also when you are having economic problems, you usually have reduced access to care, you might not got to therapy as often, you may cut back on your medication to save money, you might not be eating as well or exercising.

There are also studies that show that in times of unemployment heavy binge drinking increases. That confuses the results as well as other substances doing the same thing. And many of the studies that have been done were done in other countries where employment and insurance benefits are not tied as closely in the U.S.

And here just recently, just two weeks ago, a study came out that showed that in 2007 illness and medical bills contributed to 2/3 of all the personal bankruptcies. So poor health contributes to economic problems, not just the other way around.
And then finally, studies have shown that men are more affected by unemployment as far as the risk of suicide. And men are already at higher risk of suicide regardless of unemployment.

So what this all shows is that actually it's not that loss of employment causes suicide, but loss of employment is associated with depression, not surprisingly with problems with substance use and with marital turmoil and all of those are independently linked to suicide risk.

I do want to be careful to say that association is not the same as causation. So I show these slides and then people ask me, "Well, okay, but is the economic crisis - aren't we seeing more suicides?" And the answer is we don't know yet. Two-thousand and six data just became available on the national level. We did see a slight increase in the rate in 2006 of suicide, primarily among men in their late 30s and in their 50s.

It takes a long time to get national data and it takes a lot of numbers to be specifically significant. So data might not really help with these rapidly developing events like we are seeing, but it can provide important context.

I think in conclusion, with looking at all of the research that we've looked at, we can expect a sharp downturn in the economy like we've been seeing to increase the risk of suicide especially among working age men and among those older adults whose retirement security is threatened. And therefore the bottom line is that prevention is really important.

I asked earlier whether the financial crisis is like other crises in terms of a natural disaster, but unlike a mass natural disaster, suicide is a relatively rare event in most communities. So knowing what we know, knowing that we can expect the risk of suicide to increase we can replace buffers in the system. How can we train people who work at stress points like bankruptcy court, divorce court, foreclosure proceedings to recognize warning signs and to know how to respond?

The warning signs exist in two tiers and the first tier is the most important one. These are the warning signs in which you get immediate help, if someone is talking of hurting or killing themselves, if they're looking for ways to do so or if they're talking or writing about death or suicide when these actions are out of the ordinary for them.

The second tier of warning signs are not quite as urgent but they are still to be taken seriously and we encourage you to call a crisis line or contact a mental health professional if someone shows any of the behaviors that are on the screen in front of you and I won't read them all.

So I want to move from warning signs to risk factors because I was talking about increasing the risks. There's a difference here, if you have a stroke, a warning sign of stroke could be blurred vision, blurred speech, one side of the face drooping, it's an observable behavior. But a risk factor for stroke is having high blood pressure, smoking and a family's history.
We look at the risk factors and we look at protective factors in suicide prevention at a number of levels. And the idea here, although we present them on two sides of the screen, it's not that they completely balance each other out in a perfect way like a scale, but that they're cumulative, there's no one single factor alone.

And in suicide prevention, we try to focus our efforts on overall trying to decrease risk factors and trying to increase protective factors. There are several of these that relate directly to the notion of economic problems and you'll see those in italics. These are at the individual level, unemployment, failure and academic problems place an individual at greater risk.

Moving up a level or out a level, at the peer and at the family level we see that both barriers to healthcare and mental healthcare increase risk and having access to comprehensive healthcare increases the protective factor. And although I'm italicizing those, I invite you to also pay attention to things like interconnectedness and the sense of social support. So often with losing employment, we lose some of that as well.

At the community level, again, unemployment shows up as well as those barriers or accessed care. And then moving out to the level of the society, again, access to care and economic instability, social disintegration are associated with increased risks. When those factors are at play in a society we find more individuals and more populations at risk of suicide.

So what can we do about all this? It's pretty easy to get swayed by all of the negative headlines that we see. So those of us who are involved in media outreach, we can try to temper that sensational bad news. We can encourage more support and services that are more accessible to those who need them. We can be compassionate to people who are affected. We can try to help people who are affected cope more effectively. And we need to address both acute and chronic stress and distress and promote the warning signs that I showed you and appropriate responses to them.

We should also include a referral phone number and information about local crisis intervention services. SAMHSA funds the National Suicide Prevention Lifeline that is available 24 hours a day. It's free, it's confidential and it connects you with a crisis center closest to you based on the phone number from which you're calling. It's good for you and it's good for you if you're concerned about someone else, not just yourself.

When we talk about preventability, I think there's a few things that's important to remember. Most people who attempt do not go on to die by suicide. They get help, the crisis passes, they realize that life is worth living, their circumstances change and they do not go on to die by suicide. Particularly among youth, suicide is often an impulsive act and we can get through that immediate crisis, the person is in a much more stable position.

Suicides can also be prevented because having convenient means makes those impulsive actions much easier. So if we restrict access to lethal means, it can make a real difference. This has been found with erecting barriers on bridges, making it much more difficult for people to jump. It makes a real difference when we lock up firearms when they're not being
used and store the bullets in a separate locked location away from them. Again, particularly among youth, removing access to lethal means really prevents both impulsive actions from which there may be no return.

So what you can do, what we all can do to respond to these risks is to ask, ask the question if you're concerned about someone, reach out to them. Several of these we talked about before. Watch out for precipitating events and respond with empathy and help and connection. We all know people who are going through crisis right now and we can reach out to them.

Many of the points on these slides were drawn from our talking points on the relationship between the economy, unemployment and suicide, which is on our Web site and the URL is there.

We also have some resources here and I know this whole Webinar will be archived, so you can find these later. The warning signs that I showed you are all available on our Web site, some information for them media on how to report safely on a suicide. And then recently, the National Association of School Psychologists came out with resources that are useful in economic crises for students, parents and staff that are available on their Web site.

An entire Webinar devoted to this topic is also up on our Web site and we invite you to contact SPRC for more information on these topics or others related to suicide and suicide prevention.

So with my last slide, I just want to return to the question of is the crisis causing suicide? And our bottom line message is to take suicidality very seriously, but to keep in mind that in the midst of all of these losses that I started by talking about, the foreclosures, the bankruptcies and the layoffs, most people who are experiencing them are not suicidal, are not attempting suicide and are not dying by suicide.

After the tsunami, the World Health Organization and others did some assessments to determine what where the most pressing needs among the survivors of the tsunami and other mass natural disasters. And they ended up dividing people's mental health needs into three groups. And this is from the public health perspective, not from an individual clinician's perspective. And they found 20% to 40% of people affected fell into the group of mild psychological distress that resolved itself within days or weeks. And they may have needed intervention, but they didn't need any specific intervention.

Thirty to 50% or people had moderate or severe psychological distress that resolved with time, but they would really benefit from a range of interventions, both social and psychological to reduce their distress.

And there were some people who had mental disorders including mild, moderate and severe. Usually there's about 10% of the population who have mental disorders before there's any crisis. These researchers found that we could expect that to double to about
20% after exposure to this severe trauma. And it might take a number of years for that rate to decrease and settle down at a lower level, perhaps 15%. Those folks needed a lot of help.

And then finally there might be 2% to 3% of the general population suffering from severe mental disorder, that might again double after exposure and they might need very, very intensive services.

So with that in mind, I think we can expect there are more people in crisis, there are more people experiencing crisis, more services are needed and it's tough to provide them in time of decreased resources, but it's really important that we do so.

With that I'll end my portion of the presentation and pass it on to my colleague.

Michelle Hicks: Great. Thank you, Anara. Now we will hear from Heidi Bryan. Heidi?

Heidi Bryan: Hi. Thank you for asking me to speak. And thanks Anara, I found that to be very helpful. My role will be basically to talk about my experience in dealing with being suicidal and also losing my brother and other family members to suicide.

And I guess I'll just start by saying that I don't really remember exactly when I first started to think about killing myself. It was at a very young age. I really don't - I had lost a brother who died before I was born and I related to him, I was told I looked like him and I acted like him. And, you know, initially I would pray to him as my guardian angel and then soon that turned into I wish I were him and then it should have been him who lived and me that died. And soon I was just wishing it was me and thinking about it and figuring out ways to do it.

Needless to say, I grew up in a household where the easiest way I can describe it is to say, you know, if you pick and abuse, (I can match) the family members to it. So there was a lot of abuse, a lot of substance use and bipolar disorder. Three out of five of the members have bipolar disorder and we lived in a rural, low income setting. And back then too, there just - there were a lack of services and lack of knowledge. So I think all that combined into a perfect storm for me.

In high school, I contemplated killing myself and the main reason I didn't is, I lived in the country, as I said and I went for a walk and was deciding whether or not to do it and I noticed the mountains and I thought they were beautiful. And I thought, "Oh, wow, you know, if I can still see beauty in this world, I guess there's, you know, I guess there's still a point to living." So that really helped me and I really connected with nature and I think that was one of my saving graces.

Also - and I don't recommend this for anybody, but for me I started drinking in high school and I really think that initially it did save my life. It provided an escape from the pain I was in. Again, I don't recommend it. It ended up also, at the end being more harmful than good. But I do think initially it did save my life.
And as I - you know, I went to college and my drinking escalated and so did my suicidality. My - first semester, senior year I suffered my first major depressive episode. I didn't realize it; I didn't know what it was at the time. I just remember feeling - I had to take incompletes and my friends - I started to isolate and then they also didn't know how to deal with me, so that - so I felt abandoned also and which just added to it all.

And I really - it was - I lost a lot of weight. It was a classic major depression, but as I said, nobody knew it, I didn't know it and I was just continuing on. When I came back from Christmas break I found out that a classmate of ours had killed herself. And I had been seeing a therapist, a guidance counselor in college because as soon as I heard that you could get free counseling in college I went because I knew I needed it.

One thing about having - growing up with like no self esteem is that I recognized that I needed help and I didn't have a problem with that. So I went for help as soon as I could. But I had stopped seeing him. And then the same women - the same college, my classmate who killed herself had been seeing him. So I stopped seeing him and I ran into him and he saw me and he knew right away because I'd lost a lot of weight and everything, that something wrong and he was like, you know, "What's up?" And I just said, "Well I didn't want to bother you because I knew what happened." And he welled up and said, you know, "Heidi, I don't want to lose another one. Please come back." And I did and he really helped me get through the rest of that second semester and I really will never forget that. I'll never forget that encounter and never forget his help and him helping me.

After college, I, you know, got a job, moved away. And the thing with that is that I don't know what I was thinking but, you know, I guess I thought if I moved away from the area from where I grew up everything would be fine. But of course, you know, I moved with me, so everything was the same and my drinking escalated. And I got into an abusive relationship with a married man. He left his wife, moved in with me and whatever we had between us moved out when he moved in and in no time it was physically abusive. And naturally my drinking started to increase even more and then I really was really struggling with my suicidality and really I was struggling.

And my mother came to visit me and took me to the doctor because I had been having a lot of sore throats. And I was mortified, she went into the doctor's office with me and, you know, because I was like 24 or something and here my mother's going to the doctor with me. And she told the doctor, "You know what she needs?" And he started to say, "Don't even talk about tonsillitis and..." And she said, "No, she needs a psychiatrist. She's depressed."

And he gave me a referral and that was the first time I went on antidepressants. And they started to work, but the person I was living with hated them. And whenever we had a fight, he would take the antidepressants and throw them or whatever.

So we had started to see a marriage counselor who said, "No fighting. When you get that way, just leave the apartment." So it started again. He left the apartment and I thought, "Oh, I have to hide my pills because he's going to start this thing again." And I thought, "Where can I hide them." And then I thought, "Oh, I know, I'll hide them in mouth." And I did. I
had them all in my mouth and at this time - these were the - they would have done the job. And the only reason I didn't swallow them and take them all is because I knew I was going to be found.

And that was really - I aborted it because I knew I'd be found. So it turns out, the next day I was seeing my psychiatrist. He - I told him about it. I downplayed it and pretended like it was nothing, but he knew better. And he actually followed up with a phone call at my work two days later to make sure I was okay, which again, has always stuck with me and I really appreciate him doing that.

You know, to make a long story short, I finally I did leave this man. I met the person who is now my husband. I got into recovery for my alcohol addiction, but I was still struggling with depression and I was still, you know, I felt like I can't even be an alcoholic in recovery right, you know, what's wrong with me.

And I was figuring I had enough and I had a plan and a backup plan and a backup plan and a backup plan when my brother killed himself. And suddenly I realized that suicide was no longer an option for me. We didn't have the greatest of relationships and I didn't even know if I still loved him when he died. And I was floored by my reaction, which I felt like somebody came from up behind me and hit me on the back of my head with a two by four and I was leveled. And all I could think of was, if I feel this way, what on earth must his children and his wife and everybody be feeling?

He was fired. So he got this - I just had this moment of clarity where I realized that whatever his bipolar disorder was telling him, that we'd get over it, that we'd be better off without him, who cared, all those things that he was thinking because that's why what I was thinking, it wasn't the truth. And then I realized if that applied to him, it had to apply to me. So I knew I could no longer kill myself.

I wish I could say that things got, you know, instantly better, they didn't. I sank into another major depression, but with the help of my husband I got help and this time I stayed with it until I got the proper help. And it took a while, it took different doctors, different medications, but I stuck with it and now my life is completely different and I enjoy life and I enjoy waking up each day instead of waking up and wondering if today's the day I'm going to die.

So because of that, because I've been on both sides of the issue, I started Feeling Blue Suicide Prevention Council. We do outreach, we try and teach people the warning signs, risk factors and just to let people know, you know, what we - you know, that being a friend can - has the potential to save a life and not to be so afraid of suicide.

Like, I always tell people, when I was first asked and finally asked, "Are you suicidal?" I was so grateful. I thought, you know, finally we can get over this. You know, I needed to be asked that because I was too ashamed to say it. So it seems like - and I know it's a hard question to ask, but it's an important question to ask and if they say, yes, you know, you can take them and get help, you know, it works. And, you know, it's not rocket science, it's just really
being a friend and learning the warning signs and risk factors and not being afraid to ask the question.

You know, I think I'm being asked all the time, is the economy - and I'm seeing all these - sorry, my slides are jumping around and I don't know why.

But anyway, and I do see - I mean, I don't know. Anecdotally I'm seeing more suicides, but I - you know, like Anara said, it'll take a while till we find out for sure. What I do know is like, for my brother he had a lot of other problems going on, but his being fired was his trigger. And that's the thing with suicide, there's no one cause, there's no one problem, there's many, it's a multitude and there's no one answer unfortunately either.

And, you know, I now have to - I view my depression and my suicidality as a chronic illness. I try to take care of myself. I try to maintain a spiritual relationship with my higher power. I reach out for help. I talk to my husband when I'm feeling bad. I have my own safety plan and I try to eat well and rest and exercise and live a more healthy life. And I know my triggers and my stressors and I know the important thing is to ask for help.

And I just think - I don't believe that every suicide can be prevented, but I do believe that there's a lot more than can be and that as we continue we will - and learn more, more lives will be saved.

And with that, I will hand off to Diana.

Michelle Hicks: Great, Heidi. This is Michelle. I just want to thank you so much for sharing your story with us and the valuable resources of your organization.

Next we're going to go to Diana Morales.

Diana Morales: Okay. Thank you so much for having me and to SAMHSA for allowing us to talk about a new program that we launched right before Mental Health Month this year called Live Your Life Well.

And I just want to give a little bit of background. And I'm not seeing my slides yet, but I'll just take a moment and give a little bit of a background about why Mental Health America got started with this effort.

As some of you may know, we changed our name from the National Mental Health Association to Mental Health America in the fall of 2006. And that really was in large part in the recognition that - in the hope that we could help more and more people understand that mental health really is fundamental to every person's overall health and wellness, that it's an issue that matters to all of us. It's probably our most important health asset and that there are many things that people can do to both protect and preserve or strengthen their mental health and their overall well being.
And this isn't something that really has been new to our organization. We actually started out in 1909 as the National Committee on Mental Hygiene. So we've always had a public health focus, a population focus, if you will. And I think collectively all of the organizations, federal agencies, et cetera over the past decades have made incredible strides in reducing stigma around more common mental health conditions like depression and anxiety disorders.

We haven't done as much really to talk about a movement outside of the United States that's actually been taking place for the past decade or so around positive mental health, which we really just think of as mental health promotion.

And when you look at the prevalence rates of mental health conditions in this country, that over 26% of the population has a diagnosable mental health condition at any given time in a year, and that far too few of those people are getting help. But then you think about the overlay of all the people who are experiencing ongoing chronic stressors that - where they may not be in a situation where they don't have a diagnosable condition and yet they're not mentally healthy. And so we have a lot of work to do to reach those people and that's really an effort to work upstream.

So we started out with that premise that we wanted to create a national multiyear effort through an existing campaign that we have called Campaign for America's Mental Health that would really use this wellness frame to educate the public that mental health is fundamental to their wellness.

The next slide if someone - and I just wanted to share one of the troubles that we have had in really understanding just how pervasive stress and sort of moderate mental health if you will, but not mental illnesses in our population, but we really don't have a real time surveillance system that lets us do that.

But we do have - last year the Gallup organization and their partner Healthways have launched a 25-year initiative where they're literally going out every single day and surveying 1000 people and looking at various measures of well being. So this is all self reported well being.

And what we see just from January to November of last year, they found that while nearly half of the population feel that they're thriving - just actually a little bit more than that, 49% of the population (sort of) assesses their well being as struggling and 4% as struggling, which is still that's probably the worst possible situation you can be in. And those have been fluctuating over time, but it really gives us a sense and there is an emotional parameter in there and there's much more - we've seen a lot of the data from Gallup and it's really striking when you start to look at people who report being diagnosed with depression.

And I'm being told I can advance my own slides, but for some reason it's not happening. Okay. Here we go. So the goal of this campaign is to increase the percentage of people who begin taking one or more of ten evidence based actions to protect and promote their mental health on a regular basis. And we basically - these ten actions that I'll talk about have
been (pulled) from the literature. So what we did as we started to plan out this campaign was to
do a really thorough literature review as well as a lot of in depth interviews and focus groups, but
particularly leaning on the research to find out what are those factors that really strengthen
resiliency and promote positive mental health.

I'm not sure why - here we go. Sorry, it's taking a moment to advance. So the
campaign objectives are to increase awareness, as I said, that mental health is fundamental to
overall health and well being and that there are these evidence based ways that people can
strengthen their mental health.

And then the next one is really a self efficacy objective that we increase the
percentage of people who believe that they can actually take those actions, that they have
confidence in their ability to take actions to maintain and protect their mental health.

Okay. We have pooled these ten pools of literature and research around these
ten tools from major journals like Proceedings of the National Academy of Sciences and various
behavioral sciences and medical sciences, literature and we've worked with leading experts to
review all of the information that we've put together around these tools. So we have experts on
sleep, experts on the evidence around social connectedness and helping others and spirituality in
mental health. So we've done that with each one of the tools.

So the first tool is connect with others and this is really what others have
already mentioned on the call, is really the focus on the importance of social connections or
social support. And research suggests that that helps to fight stress, promote health and it may
even lengthen one's life. And so what we provide are tips for connections. And I won't go into a
lot of it.

We have a Web site, liveyourlifewell.org, which you can visit and it goes
through all of this. So basically we try to give people information about how they can strengthen
those relationships, join support groups and so forth.

The second tool is stay positive and there's a body of research that suggests
that thinking negatively can affect your mood, your actions and your health. And so we talk
about, again, from the research, ways to stay positive by fostering optimism, practicing gratitude
and avoiding dwelling on worries and self criticism.

And there's a lot of really good research that's come out of the positive
psychology field over the past couple of decades which we definitely pulled from for this
campaign, which have been proven to be very effective tools, for instance, around having a
gratitude journal.

The third tool is about physical activity. And many of you probably are aware
of the literature that exercise helps prevent heart disease, immune system problems, it eases some
kinds of pain, but importantly many people may not know that helps to improve their mood.
I would imagine most people on this call may know that, but Americans don't know that and so we want to make sure that we're getting out that message. And so we provide some tips for exercise and tools for instance, on the Web site to free exercises on the Internet.

So four is helping others and this is about sort of the being connected to your broader community and volunteering and the research that demonstrates the effectiveness - I'm just looking at messages popping up to me, I'm sorry - the effectiveness of helping others.

And the research indicates that people who help others do experience less depression, they have greater calm and they enjoy better health. And so we talk in the campaign about things that you can do to help others even if they're very small things that can reap big rewards for you as well.

Tool 5 is about sleep. And I think it's been well established that poor sleep is linked to a greater risk of depression and anxiety and it certainly exacerbates a lot of illness and so we provide information about how to improve sleep.

Tool 6 is about creating joy and satisfaction and the research suggests that positive feelings can actually support resiliency, boost one's ability to solve problems and help fight disease. And so again, both on our Web site and all of our educational materials, we provide tips for how to go about creating joy and satisfaction in your life.

Tool 7 is eating well. And this tool is focused on all of the various ways in which eating well, having good nutrition can improve your health and mental health. It can boost energy, provide fuel to your brain and counteract the impact of stress on your body. And so we also included a lot of information about how one can achieve a healthy diet.

Tool 8 is taking care of your spirit and there is a strong body of research around people who have a strong sort of spiritual aspect to their lives, whether it's a formal religion or it's some other form of spirituality or a tool like meditation that can have a tremendous impact on combating stress and fighting disease. And so we talk about a variety of things that individuals could do in that area.

Tool 9 focuses on how to deal better with hard times. And studies have found that people who problem solved in a stressful situation actually felt less depressed and people who focuses on the positives in their lives suffer less from painful memories.

And so we talk about ways to deal better in difficult times and many, many people are obviously going through difficult times right now. So things like writing or journaling for emotional relief, listing and assessing solutions and getting the support that you need.

Tool 10 is get professional help if you need it. And we felt it was really important to put information out there that would help people perhaps better predict when they might need professional help. What we saw in the focus group that we did were that many people - and again, focus groups are much smaller numbers, but there seemed to be a lot of reluctance to
seek help for individuals who were going through significant stress. And so we've got a little bit of a wall to get past those people.

If we focus on stress I think it's something that resonates with everyone, but ultimately we want people to know what to do and where to go if they're in crisis and leave them with a hopeful message that treatment is effective and they can get better.

When we planned this campaign, our goal was to launch it last fall and then the primaries continued to go on and on and we decided that this year would be a better time to launch the campaign. And we really couldn't have known at that point that the economy was going to turn in such a huge way.

And so it's been very timely and it's been very rewarding for us to work on this effort and we really do think although these aren't - sound like simple easy things, they're not necessarily easy things to do. And so we encourage people whether it's just one thing that they do, if they start taking an action and integrating it into their everyday life so that it becomes a routine habit, just like brushing your teeth everyday or combing your hair, that these things over time really can buffer you from the ongoing stressors in life and help you lead a healthier and hopefully happier life.

So, thank you.

Michelle Hicks: Thank you so much, Diana. This concludes the presentation portion of our session. And again, I want to say a special thanks to all of our presenters for sharing with us today.

At this time we will have questions from the participants. As a reminder of the instructions, you can refer to Slide number 4. You will dial star 1 on your telephone keypad to be placed in the queue. Remember that once you've asked your question your phone will be muted.

Operator?

Coordinator: Thank you. We have something coming in. One moment. Our first question is from (Marcella Amorice). Your line is open.

(Marcella Amorice): I'd like to ask the three speakers what they would suggest for students who may have received a lot of services at the high school level in terms of mental health? And in their voyage to college what would be some of the recommendations for students who sometimes relinquish the idea that they still need mental health help? How can we go about encouraging these students to stay connected?

Anara Guard: This is Anara. I'll take a crack at that one if my colleagues don't mind. We are currently working with a number of college and university campuses across the country around their suicide prevention efforts. And I know that the counseling centers on colleges and universities are eager to connect with those students.
I don't know if you're on a campus, but the campuses are engaged in a variety of activities to reach out to incoming students, particularly to make sure that they connect them.

In many university settings, the mental health counseling center is actually integrated into the overall health center so that the student going there for services, isn't obvious if they're going there for a physical problem or a for a mental problem.

I don't know that I have a single recommended method by which outreach should be done, but I know that campuses are engaged in many different ways through the residence advisors for those campuses that are resident campuses, through faculties, through counseling services and through other methods as well as reaching out to those students when they're actually in trouble, whether that's parking tickets or academic problems or financial problems.

Michelle Hicks: Thank you. Operator, is there another question?

Coordinator: Thank you. Our next is from (Chun Yen Pew). Your line is open. Please check your mute button. Your line is open Ms. (Pew).

I'll move on. Please press star then 1 if you have a question. Our next from (Elizabeth Hill). Your line is open.

(Elizabeth Hill): Yes. I'd like to ask a question, we're seeing a lot of returns of veterans and they're dealing with a lot of emotions like they're coming back and their jobs are no longer available or their family is no longer there. And we are reaching out to them.

My question is how do you get them to continue to their treatment? I mean how can we motivate them to let them know that we care and that we're here for them? And I've seen some of them are like cutters, you know, they cut their selves and just - but then they'd say, "I'm not trying to commit suicide."

Diana Morales: This is Diana Morales. I'll take a stab at it. We have many affiliates outside of the national office across the country and many of them are working with veteran's groups. And I think one of the things is working with the families and helping them to understand what individual may experience when they come back and how to cope with it themselves but also how to help that individual.

And I think just any engaging of the broader community, any education that you can do with employers because you're right, as veterans come back they really lose their support system that they had when they were in combat.

So I would - I think a lot of it comes from educating families, the greater community and employers.

Anara Guard: I would also say - this is Anara again - that it is quite true that not everyone who cuts or self injures is suicidal. Indeed there's some research that shows it's a very different
sort of psychology and that it's a way of feeling better. That is people who do this, experience a relief from some of the feelings that they've been having. There is a Webinar coming up just focused on self injury on June 30 and you can find information about that on the SPRC Web site if you want to get into more detail about self injury although it's focused I think more on the high school level than the veterans level.

Heidi Bryan: This is Heidi. And also I believe a lot of the VA Centers are also starting like support groups and having the veterans connect with other veterans coming home so that they don't feel so isolated, that they have someone else who's gone through it and understands.

Anara Guard: That's true and in addition, the VSW has started addressing this issue, which is important too because there are many veterans who do not qualify for VA services, but can find companionship and services through their local Veterans of Foreign Wars branch.

Michelle Hicks: Thank you. Operator, do we have another question?

Coordinator: Yes, our next - (Carla Morgan), your line is open. (Carla Morgan) please check your mute button. Again, please check your mute buttons when you do queue up for a question.

Our next then from (Jennifer Aleema). Your line is open.

(Jennifer Aleema): Yes, I am (unintelligible) working primarily with members in our community who (unintelligible) diagnosis. And I was wondering specifically, because so many of our members go in and are evaluated for suicidal ideation, what kind of suggestions or recommendations you may have for them or for us rather to help them better.

Heidi Bryan: I'm not sure I understand the question and if I do I don't think I'd have enough time.

(Jennifer Aleema): I was wondering what we can do as case managers or social workers to better help our members who have often (unintelligible) suicidal ideation and they're going into the hospital pretty frequently because of it.

Heidi Bryan: Well, I know some places that are in Philadelphia that I work with have started a Suicide Anonymous, which is a peer support for people who are chronically suicidal, who have attempted multiple times and they're finding that to be helpful.

And just - I think part of the thing is that the people I've talked to who have attempted have always said that one of the best things is to be able to talk about it with someone else. So to be able to talk about it with their case manager and not have to fear being hospitalized or something like that, but to discuss it openly and honestly and, you know, what can we do, you know develop a plan with them, work with them, talk with them to figure out how, you know, we can keep you alive or how can I can keep me alive sort of thing.

Michelle Hicks: Thank you. Operator, is there another question?
(Larry Ackerman): Yes. My name is (Larry Ackerman). I work for NAMI Michigan and I'm the state trainer for Connection Recovery Support Groups here in Michigan. My comment isn't so much a question as a comment. I find that the day I have my Connection Group here at my office many of the ten tools that you outlined are automatically kicking in. I sleep better, I'm staying positive, there's that definite sense I'm helping other people by my being a Connection facilitator. I'm connecting with the members of my group and those times when they're - members of the group are in crisis or having a rough time, helping them to get professional help reinforces for me that getting professional help is okay.

And of course, you know, I have a formal diagnosis of schizoaffective disorder so taking my medication is part of - if I didn't do that I wouldn't sleep well. And everything about the program is keeping me doing far better than I would without it. That's all I had to say.

Michelle Hicks: Thank you so much for sharing that. Operator, do we have another question or comment.

Coordinator: Yes, (Elizabeth), your line is open now.

(Elizabeth Hill): Yes, I wanted to make a comment. You said that they didn't have medical or VA related. Anyone returning from home - returning back home once they've been to Iraq or, you know, the OEF/OIF programs, which is Afghanistan, Pakistan, you know, Peru, any of those places, they will receive free medical up to five years. So I wanted to let anybody know that's out there that that service is being offered.

Michelle Hicks: Great. Thank you for sharing that information. Operator, do we have another question?

Coordinator: Presently, two more. (Carla), your line is open.

Michelle Hicks: (Carla)?

Coordinator: Please check the mute button, you line is open. I'll move on. Then we have one more. (Patricia) your line is open now.

(Patricia): Thank you. I also am a suicide survivor and I have found - you mentioned journaling as being very helpful, but more than that is self expression. To me acts of creation are a direct link to God and it's spiritual and there are all kinds of ways you can be creative with very few materials, just doodling for instance and actually (Rorschaching) them. And of course, listening to music and theater and the arts, performing and visual I think are crucial to keeping spiritually sane and stable in addition to medicine and people to educate you on how you're experiencing your illnesses and the need to die.
So I agree with everything that everybody has said and add the spiritual self expression. Thank you.

Michelle Hicks: Thank you.

Woman: Thank you.

Diana Morales: Thank you for sharing that. I think it's important that not everything that we do be text based or language based, that although articulating our feelings into words is one important way, it certainly isn't the only way.

Michelle Hicks: Thank you. Are there any other questions in the queue?

Coordinator: Yes, a few more have developed.

Michelle Hicks: Great.

Coordinator: (Unintelligible) your line is open. (Vymette) your line is open. Please check your mute button.

Okay, I'll move on. (Rosemary) your line is open.

(Rosemary): Hi. This is (Rosemary). I'm a NAMI Connection Recovery Support Group facilitator and trainer in Collin County, Texas. And I think everything I'm hearing is really encouraging. And I think the key is to reinforce recovery because I never knew that recovery was an option through the years of my struggle and through family struggles with mental illness.

And recovery just is huge to me and the people that I've met that are doing well and high functioning. So I just wanted to make that comment. Thank you.

Michelle Hicks: Thank you.

Coordinator: (Maynon), your line is open.

(Maynon): Hi. I'm a counselor; I'm the only counselor at a community college. And as all providers are facing everywhere, we're losing - there's a shrinkage of the financial resource as well as the personnel to do a lot of these (works).

All of the agencies that have spoken have wonderful resources and I'd be the first one to say, I haven't had a chance to go through all of your sites. Are there methods on your pages; are there mechanisms that we can all network with each other and share resources, share tools, things like that?

I know I'm talking with the colleges in the area about sharing our resources with each other to try and make it a little more bearable for us.
Anara Guard: Where are you located?


Anara Guard: We don't have for instance a list (served) just for community colleges although we do operate a number of list (serves). This is Anara speaking for SPRC. I don't know if we have currently on our site the kinds of tools that you are thinking about, although they're not that difficult for folks to start up.

I do encourage you to email me directly and we'll see what we can do to provide some services.

(Maynon): Thank you so much.

Diana Morales: And this is Diana at Mental Health America. If you go to our - we have quite - we have many affiliates in New York State. If you go to our Web site mentalhealthamerica.net, you can look up where affiliates are. There may be one right near you and they can certainly work with you and see what resources they may be able to provide to you.

(Maynon): Thank you so much.

Heidi Bryan: And this is Heidi. And you can email and I can - we have some like - we have a Wiki space that I can give you access to with information and resources.

Anara Guard: And one last thing, just for the other people who are in higher education settings, we are adding to the SPRC Web site by the end of the summer more pages that are designed specifically for people working on campuses and in campus settings. So you may be able to find more there by the end of the summer than you can find right now.

Michelle Hicks: Thank you. Operator, is there another question.

Coordinator: Yes. (Laura), your line is open now. (Laura) please check your mute button.

(Peggy): Yes. My name is (Peggy) and I'm here with (Laura). And I wanted to know if you could direct us toward suicide prevention, (and other) resources that might be tailored to the specific population of people who are refugees and/or survivors of torture?

Anara Guard: I don't know off the top of my head of resources for survivors of torture. Most of the work that I know that's been done with that has been conducted in Canada, primarily in Toronto.

As for immigrants, we do have archived on our Web site and again it would be easier to send you the link if you shoot me an email - a Webinar that we did some years ago for the refugee and immigrant population and I can refer you to that.

Michelle Hicks: Thank you. Operator, is there another question?
Coordinator: Yes, (Joe), your line is open sir.

(Joe Espinota): Yes, hello. This is (Joe Espinota).

Michelle Hicks: Please ask your question.

(Joe Espinota): Yes. When is it the responsibility of the community center to obtain an application for apprehension for a suicide patient?

Anara Guard: Whoa. This is Anara now speaking. That question is, you know, beyond my knowledge space. I would think that that depends somewhat on local and state laws as well as accrediting guidelines, but beyond that, I'll be way out of my knowledge (deck) if I start wading in there.

Perhaps somebody from the ADS Center might know.

Michelle Hicks: No, I'm sorry. I do not have that information off hand. I would encourage you to send an email to us and we will try to research at least some additional resources that you could possibly find that information out.

Diana Morales: This is Diana. The one other place I would suggest is the Bazelon Center.

Michelle Hicks: Thank you. Operator, is there another question?

Coordinator: Yes. (Stephanie) your line is open, ma'am.

(Stephanie): Hello? Hello?

Michelle Hicks: Yes please ask your question.

(Stephanie): Yes, I'm a bipolar nurse, unemployed, raising a bipolar daughter. Is there any program or suggestions you can have for being a parent of a bipolar child?

Anara Guard: There is an organization called DBSA, the Depression and Bipolar Support Alliance and their Web site is dbsa.org. And I believe they have a lot of resources available for parents like you and like me for that matter.

Diana Morales: This is Diana. And there's also the Bipolar Children's Foundation.

Heidi Bryan: And (unintelligible) NAMI has area resources also.

Michelle Hicks: And if you need additional information or if you need that repeated, you could send an email to the ADS Center and we could respond to you with a listing of all the resources that you may find useful.

Thank you. Next question.
Coordinator:    (Carla), your line is open.

(Joanne McGee): Yes. This is (Joanne McGee) on (Carla Morgan)'s line.

Michelle Hicks: Yes. Please go ahead.

(Joanne McGee): Yes, there were ten ways of lessening depression and suicide. I got numbers three to ten, but I missed the first two. Can someone give me those?

Michelle Hicks: Actually if you - the slide presentation is available for download. So you could send an email to the ADS Center or you can send a question to me if you're on line in the meeting site and I can send that link to you right now and you'll have them all at your fingertips.

Diana Morales: And it's Diana. It's actually really easy if you just go to liveyourlifewell.org and they're all right there.

(Joanne McGee): Live - okay.

Diana Morales: Liveyourlifewell.org.


Diana Morales: Sure.

Michelle Hicks: Operator, do we have another question?

Coordinator: Yes. (Anita), your line is open, ma'am.

(Anita Pullman): Thank you. My name is (Anita Pullman). I work for Community Research Foundation in San Diego. Someone asked a question earlier about help for survivors of torture. And in San Diego County there is an organization called Survivors of Torture International.

    They have many, many, you know, media and movies and presentations that they come and do all over the place. So the person who asked the question hopefully is still listening and if they could either Google them - I believe their Web site is notorture.org. Hopefully that will provide some additional assistance for them.

Michelle Hicks: Thank you so much for sharing that.

Woman: Thank you.

(Anita Pullman): You're welcome.

Anara Guard: Michelle, I know that there's an online question as well. So just let me know when you want me to address that.
Michelle Hicks: You can go ahead.

Anara Guard: Okay. This is Anara again. And someone had noted that I had stated earlier that most suicides are impulsive especially with youth and they wondered whether that meant that there was not mental illness in the background of those youths or whether there were triggers.

The studies of youth show less prevalence of mental illness in youth than in older adults who died by suicide or who attempt suicide. And that makes sense; often mental illness doesn't occur or manifest itself until a little bit later in life.

And yes, there are triggers. For many youth it's the breakup of a relationship, often combined with other factors like academic problems in the school, substance use and the other big risk is run-ins with the law, getting arrested. You know, when you're young you feel like crises like this are failures that will haunt you for the rest of your life. And those are the kinds of things that often trigger suicide attempts among teenagers.

Michelle Hicks: Thank you. I also have a question online that I want to share with everyone. Someone did try to pull up dbsa.org and it came up differently. So the URL for that is dbsalliance.org.

Woman: Ah, very good. Thank you.

Michelle Hicks: Operator, is there another question?

Coordinator: I have no further questions on the phone lines.

Michelle Hicks: Great. Well, since there are no other questions coming in the queue and it looks like we have answered the questions online, then this is going to conclude our training for today.

If you did have a question, you did have a question, you did not receive the answer that you were looking for, please feel free to email the ADS Center or to email any of the presenters. You will find their contact information on the slides.

If you are interested in receiving the slides, reviewing the slides or hearing the audio portion of the training, that information will be available along with transcripts in another few days on the SAMHSA ADS Center Web site.

Again, I want to thank you all for participating and reference Slide 57 and 58 for additional resources and again feel free to contact the ADS Center or any of the presenters for follow up.

Thank you and we'll see you next time.
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