Defense Suicide Prevention Office Podcast Transcript

Crisis Prevention

Ms. Ashby Dodge: Hey everyone. Thanks for joining DSPO's "Mental Health is Health: Maximizing Your Well-being" podcast. I'm Ashby Dodge, senior adviser for crisis response at the Defense Suicide Prevention Office.

Today we are going to talk about crisis response with Dr Richard McKeon, senior adviser for 988 for SAMHSA'S. Richard McKeon, PhD. , MPH received his PhD in clinical psychology from the University of Arizona and a Master of Public Health in health administration from Columbia University. He has spent most of his career working in community mental health and has worked with the National Suicide Prevention Lifeline since its Inception in 2005, including establishing the foundation for 988 as the National Suicide Prevention Number. Welcome, Dr. McKeon. I'm so excited to talk to you about crisis response and what you've learned about the best way to support the military community. So, to start us off, would you take a moment to tell our listeners about yourself and your background?

Dr. Richard McKeon: Sure. I would be glad to Ashby, and it's a pleasure to be here with you today having this conversation. So, the first half of my career, as you mentioned, was in community mental health. I served as the director of psychiatric emergency services at a hospital-based community mental health center and then later as a clinical director for that service. And then, about midcareer, I transitioned to Washington D.C. and had the opportunity to work for U.S. Senator Paul Wellstone and then came to work for SAMHSA, the Substance Abuse and Mental Health Services Administration, one of the operating divisions of the U.S. Department of Health and Human Services. And I was the first person at SAMHSA said to work full-time on suicide prevention. I worked with the development of all of our Suicide Prevention Grant Programs, and as well as you said when you kindly gave that biographical sketch with the National Suicide Prevention Lifeline since its inception in 2005 and then through now the work with 988 as the new number that's built on the foundation of the 200 plus crisis call centers across the country who answer calls from 988 and as well as provide services in chat and text.

Ms. Dodge: That's amazing! You are a leader in the field and someone that I know everyone knows and respects. So, it's so awesome to have you here. So, what would you say is a crisis response system?

Dr. McKeon: Well, I think that the most important thing about a crisis response system is that it's more than individual crisis services. But it's having a continuum of crisis services, but not only a continuum, a coordination among those different components. In many ways in terms of suicide prevention in the United States, one challenge has been fragmentation of services. So, you know we know this. We know that there are high risks even for after discharge from intensive services like inpatient care, or when somebody leaves the emergency room. What we you need is a continuation of services that are coordinated.

SAMHSA's National guidelines for behavioral crisis services speak of three elements or three core components that our goal is for every community in the United States to have access to. Sometimes we talk about this as someone to call, someone to come, and a safe place for help.

Now with 988, we have we have a number that can be called that can be answered 24 hours a day, 7 days a week, 365 days a year. But sometimes there's a need for more than can be handled on the phone. Now a good 80% of the time, the issues that somebody is presenting with when they are in crisis can be resolved on the phone call, but there are times that there is a need for someone to come.

And the second component are mobile crisis services. In many parts of the country, we end up relying on police to respond, and we think that 988, in combination with mobile crisis services, can significantly reduce the number of times where police are required. Again, a good 80% of the time, from the programs that we've spoken to and monitored, a good 80% of the time that a mobile two-person mobile crisis team going without the police can provide what is needed. There will be times after even a mobile crisis visit when more intensive services are needed. You know, typically in most places, you know, now that means being brought to the emergency room. We have a problem with emergency room hoarding, unfortunately, in many places where people may stay for hours or even days and sometimes even weeks, you know, waiting for care, and in many emergency rooms, there's no specialized mental health support that is available in the emergency room even though that's where care, that even though that's where people are being taken to try to get that level of care, But then they end up waiting for a bed over an extended period of time. That's why we think crisis stabilization units, non-hospital crisis stabilization units, are the important third leg of that stool; a place where people can go where they can get the mental health or the behavioral health and services that they need, including substance use services.

There are programs that are excellent that really focus on there being no wrong door and people not being refused. So, as SAMHSA's National guidelines specify, these are the three important components, but remember, as I said before, there's a need for these services to also be coordinated. Right, that's one thing, where follow-up of people after they leave one service transition to another becomes critically important. We know that contact during these times of acute crisis when somebody's thinking about suicide can be particularly important. So that someone knows they've not been forgotten that they're not left to negotiate a complex system on their own. So, the idea of a continuum with these three key component services, there are certainly others that crisis services that are also important, and coordination to make sure that there's follow up until the person gets to a setting, it could be outpatient services, psychosocial rehab, it could be a number of different things that they can get to that can meet their needs on an ongoing basis.

Ms. Dodge: Yeah, awesome, and I, you know, like as you said, you know this the system is pretty complex, and so you know this can be very intimidating, especially for folks that aren't in the field. So, what would you say is the most important thing each and every one of us should know about responding to someone in crisis? So, no matter if we are a clinician, if we are in the field of suicide prevention, or, you know, someone who knows someone who might be suicidal, what's the most important thing each and every one of us should know?

Dr. McKeon: Well, I would say that there are two things. So, one is to be willing to ask the question of about whether someone is thinking about suicide. It's a really important question to be asking, and it's often not asked routinely, including by mental health clinicians. In fact, in between the evaluation studies SAMHSASHA did between 2001 and 2004 found that even on suicide hotlines, people were not being asked routinely, and for that reason, the Lifeline implemented standards for suicide risk assessment so that everyone would be asked not in a rote way but in a caring and concerned way because there are times that people may be thinking about it, they may not bring it up themselves, but if asked they will respond and share.

Then the next piece of that is that if the person is thinking about suicide, not to panic, right? The fact that somebody is thinking about suicide doesn't mean they have to immediately get to an emergency room, right? But they do need to talk to somebody, and they need to talk to somebody who is skilled in doing a compassionate suicide risk assessment, who can assess their level of need. You know, there are people who have chronic thoughts about suicide but haven't acted on them. They may need support and help but don't necessarily need to go to immediately to the emergency room.

There are others, you know, where the risk might be much more acute, and so somebody who knows how to do an assessment of that risk and knows the different levels of follow-up that might be needed there - will be times some people may need to go to the emergency room. For example, there was a suicide attempt in progress where we want to make sure the person gets checked out medically so that they can survive, you know, their suicide attempt.

And then the other piece to that for everyone to know, including clinicians, but also family members and friends who are concerned about a loved one, is that 988 is available around the clock. It's an easy-to-remember number, and it is available not only to someone who may be thinking about suicide, it's available to family and friends who may be concerned about someone. They can call or talk to one of the 988 counselors and get advice and guidance about how to best proceed regarding their friend or loved one.

So, those are the things I think. Always be willing to ask the question. If somebody's not thinking about suicide, it's an easy no. People don't get upset that you ask that question if they're not thinking about it. So, there's really not any downside, particularly if it's done in a caring and compassionate way.

Ms. Dodge: No, totally, and I was talking to someone this morning about this specific point, About literally asking someone if they're thinking of killing themselves. Are they thinking about suicide? Because I think a lot of people are afraid to ask that direct question, but when you do ask that direct question, it also shows the person that you are able to have this discussion, and you're there with them in that moment, and I think it's a really powerful move to create that connection with them. So, I agree that that's a big point to throw out there.

I think it's pretty much the same, but is there anything else you can share about suicide prevention in general? About if there's any additional things that you think that folks should know about in terms of responding or assisting someone in general in suicide prevention?

Dr. McKeon: Well, I think that you know, so, we've talked about the importance about knowing where crisis help is, being willing to ask for that for that help. I think it's also important for people to be aware that there are scientifically validated treatments that are available, particularly in outpatient care, that there are things like what is called dialectical behavior therapy, collaborative assessment, and management of suicidality cognitive behavioral therapy. So, there are a number of outpatient treatments, but also, it's important to know that there is a lot of very solid evidence regarding the effectiveness of what's called safety planning.

You know, one thing that we used to do in the mental health field that was problematic what was called no suicide contracting, right? That was because clinicians needed to have something to do. So, they would ask people to contract for safety. Not only was there no evidence that that was effective but there was actually evidence that it could be harmful because people experienced that as being kind of for the clinician rather than for the patient. That it was basically to kind of alleviate anxiety about legal liability. But now the research is very solid that safety planning is is effective and what safety planning is working collaboratively with someone to keep themselves safe. There are multiple components to safety planning, you know, and it involves who to call, but also, not only professionals but who are safe people for you to talk to. What are skills that you can use when you're having a hard time? And safety planning is what's most important. Is it a collaborative effort and that's really important for people to be aware of. If they're having thoughts about suicide, right? That the standards within the field have really moved to emphasize the importance of collaborate. If somebody is willing to collaborate with us to keep themselves safe, then we can work with them in a variety of different ways, and that's, and that's really important.

And I said the scientific evidence is very solid. One of the things that is particularly useful about safety planning is that it can be done in a number of different settings. It can be done on a 988 call and can be done in an emergency room. It can be done in an outpatient settings and in fact there are two major studies that showed that the combination of safety planning in the emergency room and follow-up calls afterwards led to decreased suicidal behavior and increased linkage to needed mental health treatment.

Ms. Dodge: Yeah, that's awesome. Great! Yeah, I totally agree. Shifting gears a little bit, what more do you think the DoD or Services can do to support and advance crisis response across the military community?

Dr. McKeon: Yeah, well that's a great question. I think that, you know, the Department of Defense has been a leader in suicide prevention for many years, really going back to one of the first demonstrations of successful suicide prevention which was the Air Force model back in the 1990s and which was published. One of the things that was important about that is that it was multi-component, right? That it was so it was not only about crisis care, but it also wasn't only about mental health care, it was about being aware of the wide range of contributants to someone being in a suicidal crisis.

You know, being aware of the kinds of situations, financial concerns, legal concerns that could lead to, you know, to a crisis. So, I think that, so one issue is coordination, you know, so one is having access to a comprehensive approach, right? And this applies to the military, just as it does on the college campuses,

for example, or for communities at large, and of course Service members and their families, are part of their communities, and so those linkages within the community is really important.

The issue of access to crisis services through calling 988 for example, or the ability of a mobile crisis team which could come to a Service member if they're living in the community, if somebody is living on a military base then having arrangements where, for example, where it would be clear that a community mobile team could go, could enter the military base, to do a mobile, you know, visit is important.

You know, I also think, you know, communication becomes key. I had the honor of being on a Department of Defense task force a dozen years ago that was mandated by Congress, and you know, one of the things that we looked at was the need for communicating, that having thoughts about suicide and telling someone about that was not going to have a negative impact on your career in the military, right? And, you know, and in fact, you know, many people can be having suicidal thoughts can be successfully treated on an outpatient basis even without the need for hospitalization, and in fact by collaborating on something like a safety plan can help prevent the need for further more intensive services having to utilized.

Ms. Dodge: Absolutely. Thank you. Are there any other final thoughts you'd like to share with our listeners about maximizing your well-being?

Dr. McKeon: Yeah, well I think that, well, I think that one of the things that is most important is to learn how to accept what one is going through emotionally, right? Be willing to share that with others, you know, particularly men of my generation were not necessarily brought up to be emotionally expressive or to share about their emotions, but it is really important to be able to feel connected to other people when you're having a difficult time, right? And so that is something that I think all of us can learn to do better. But I think, you know, we have higher suicide rates in the country as a whole as well as in the military among males, and Nationally, suicide among older adult males is, you know, higher than for most other groups. And so not allowing oneself to get isolated, to stay connected with other people, right, you know, is a hugely important thing to maintain one's wellness, right, and I think that whether you're old, or young male, or female, transgender, whatever that connectedness the support of a community around you there.

The other thing I would just mention is that we know that the military is a tight-knit community and one thing that's often an issue for Service members is when they transition out of the military not necessarily having that same level of connectedness. So, that's a really important element of what needs to be maintained, you know, for wellness.

And then I think the other is that if one should have thoughts about suicide, to be willing to talk about them and to realize that the word suicide do, you know, does not mean that anyone having a suicidal thought needs to be rushed by in an ambulance to an emergency room, What it does need is there's a need to talk to somebody, there's a need to connect to somebody, and there's a need to think through what's driving that, so, what could be most helpful.

Ms. Dodge: No. I totally agree, and whether it's, you know, like you started at the beginning about talking about expressing your emotions or someone reaching out and saying they feel suicidal, that takes an intense amount of vulnerability, and that's the way we can continue to make that connection and to keep that connection going so that folks don't live in isolation. So, I thank you so much for joining us today and for giving us - sharing some of this information with us. As always, it's an honor and a privilege to talk to you and I will look forward to talking to you soon.

Dr. McKeon: Great. Thank you, Ashby, for having me on.

Ms. Dodge: Thank you again for being with us today to discuss crisis response. Listeners, please help us spread the word by liking our podcast and sharing it with your contacts on social media. To access more podcasts and resources in DSPO'S Resource Library, visit us online at www.DSPO.mil. If you are a Service member in crisis, dial 988 and press one for the Veterans and Military Crisis Line. You can also access the crisis line by text at 838255. Thank you.