Defense Suicide Prevention Office Podcast Transcript

Navigating Crisis with 988

Dr. Ramya Sundararaman:

Good afternoon. Hello and welcome to the Defense Suicide Prevention Officer's podcast series Mental Health Is Health. I'm your host, Dr. Ramya Sundararaman, the Deputy Director of the Defense Suicide Prevention Office. Today we are diving into a crucial topic — navigating crisis. We will be speaking with Dr. Richard McKeon, who is widely known and respected for his work in suicide prevention and intervention. Personally, I have gained a lot of knowledge and expertise from Dr. McKeon over the past 25 years. So very grateful to have you here Richard. Dr. McKeon serves as a senior advisor in the 988 and Behavioral Health Crisis Office after having served 12 years as chief of the Suicide Prevention Branch Center for Mental Health Services for Substance Abuse and Mental Health Services Administration, also commonly known as SAMHSA. Thank you for joining us today and welcome to our podcast. Dr. McKeon, again, thank you for being here. Would you like to tell us about your work in the field of mental health and suicide prevention and your involvement with the 988 Suicide and Crisis Lifeline?

Dr. Richard McKeon:

Sure, I would be happy to and thank you for inviting me to participate in this podcast. So, I am a clinical psychologist by training, but I also have a degree in public health. So, I focus both on community as well as clinical approaches. I spent the first half of my career working in community mental health in the state of New Jersey and served as a director of a psychiatric emergency service, and also as the clinical director for a hospital-based community mental health center. So, in those roles, I frequently encountered many, many suicidal people and that really led me to want to focus on strengthening our efforts to prevent suicide Nationally. And that was what really brought me to SAMHSA and at SAMHSA in my previous role as chief of the suicide prevention branch, I was involved in numerous initiatives, the Garrett Lee Smith Youth Suicide Prevention grants, for example, and the Suicide Prevention Resource Center. But one of the things that I worked on the longest was the launching and development and evolution of the National Suicide Prevention Lifeline. The Lifeline first received a grant from SAMHSA in 2004, and at that time we were using the number and launched the number 1-800-273-TALK. The Lifeline is set up as a network of crisis call centers around the country.

We started with over a hundred and now there are over 200 centers that are involved in answering calls for 988. So, if you call 988 or if you call 1-800-273-TALK, the call gets automatically routed to the closest local call center based on your area code. But there's also the option, as you're aware Ramya, of pressing 1 to be connected to the Veteran's Crisis Line and Military Crisis Line. There's an option to press 2, which people hear, and the people hear that part of the message in Spanish if they need to talk to somebody in Spanish. More recently, a press 3 option was added to allow for a connection to a sub-network for LGBTQ youth. So, that is the way that the system operated. Over time, we evaluated it working with Madeline Gould from Columbia and other evaluators to demonstrate its effectiveness. And so that was a background that really brought us to the inception of 988. So, I'll stop there.

Dr. Ramya Sundararaman:

Thank you, Richard. Yes, I certainly remember the start back in 2004. Could you share a little bit about 988, why it was established, and when someone should call?

Dr. Richard McKeon:

Yes. In 2018, Congress passed the National Suicide Prevention Helpline Improvement Act, and what that Act did was it called on SAMHSA and the VA to both make a report to the (Federal Communications Commission) FCC on whether a three-digit number was advisable. That report also called upon us to report on the effectiveness of the Lifeline, which we did using the extensive evaluations that had been led by Dr. Gould. And then, as the other part of the Act, the Federal Communications Commission was to take our report and the VA's report, as well as a report from one of their own advisory committees and make a recommendation to Congress regarding a three-digit number.

So, in SAMHSA's report to the FCC, there were two major things that we identified as important reasons to move forward with a three-digit number. One of those was that we thought that more people would be able to remember a three-digit number than are going to be able to remember the 10-digit number. In particular, we thought that in a moment of crisis, a 10-digit number is going to be a lot harder to remember than a three-digit number. The example we gave in our report was that it would be very likely that if somebody was suffering from severe chest pains, they were there with a family member, it would be likely that both the person experiencing the chest pains and the family member, despite the stress of that situation, are likely going to remember the number 911, but that in a suicidal crisis, the concern was that people, that too many people, might not remember 1-800-273-8255. So that was one reason that we gave. And in fact, since the launch of 988, there has been a significant increase in the number of people accessing.

The second reason that we gave in support of a three-digit number was that we thought that having a three-digit number for suicide prevention and behavioral health crisis services could play a transformative role in behavioral health crisis services Nationally in much the same way that over a half-century, the number 911 has been a catalyst for the development of emergency medical services in the United States.

The emergency medical system in the U.S. looked quite different at the time that 911 was first established. So, this went in our reports to the Federal Communications Commission. The Federal Communications Commission looked at our reports and obtained significant public input, as well as input from one of their own advisory committees, and in their report to Congress recommended that the number 988 be designated as the new National suicide prevention number. Shortly thereafter, the FCC issued a regulation requiring every, the telephone companies, to work to make sure that every landline, every cell phone, and every voiceover internet device in the United States was able to utilize 988, so that 988 would work when people dialed it and gave a July 16th, 2022, deadline for that. Additionally, Congress passed, and President Trump signed into law in October of 2020, the National Suicide Hotline Designation Act, which put into law 988 as the new number. Also, it had a number of other features helping to contribute to the longer-term financial sustainability of a range of behavioral crisis services, including the local 988 centers.

Dr. Ramya Sundararaman:

Thank you, Richard. So, the 988 Suicide and Crisis Lifeline has been around for a year now. You already talked about some impacts such as the increase in callers. Any other impacts that you've observed and any unexpected challenges or successes you'd like to share?

Dr. Richard McKeon:

Sure. I think one in particular, so there's been a lot of increased access for many people. In the year since there were over 5 million contacts. That's either by phone, chat, or text. One thing that I think is particularly important and is a particular success is that it has to do with chat and text. The FCC also ordered in 2021, that 988 had to be accessible by text and not only by traditional phone calls and gave the same July 16th, 2022, deadline for that. This is particularly important because chat and texts are disproportionately used by younger people, and also our data showed that those who access the system by chat and text were more likely to be experiencing current suicidal ideation than those who called on the phone. For those who called on the phone, evaluation studies have shown that about 23% are currently suicidal or might be a family member calling because of a family member who was suicidal.

But for chat and text, those numbers who are currently suicidal at the time of the chat and text are well over 50%. So, one of the successes was enabling the expansion of texts and significantly increasing the answer rates and the speed of answers for our calls and the answer rate for our chat and text and the speed of answer for those as well. That means that compared to previously hundreds of suicidal people, mostly young, every single day, were able to access the system who were unable to access the system previously. So, a system that had really been underfunded in previous years received a substantial boost in funding, and the crisis centers that had been heroically shouldering the burden of responding to calls and chats and texts in the past are finally getting funded to their work and have really risen to the challenge of the increased numbers through 988.

In terms of a challenge, I would say that one of the challenges that we are continuing to work actively on has to do with geo routing. And that is that when you call the Lifeline, the call gets routed, not based on your physical location, but on the area code of your phone. So, I'm here in Rockville, Maryland, and so if I call 988 on my phone, it will go to a local center every mind in Rockville. So, that is fine, but nowadays with cell phones, numbers being transportable, people move to other areas or else people are traveling. So, I was in Indiana for some meetings last week on veteran suicide prevention, and if I had called 988 from Indiana, my call would not have been answered in Indiana, it would still have been answered in Maryland. So, this is different than 911. It only takes a 911 call is the ability to locate them based on where they actually are, and in fact, that's built into the phones and can't be changed. So, that is something that has implications. We want to be able to connect people with local resources, particularly if they don't press 1, or 2, or 3. We want them to be able to go to the local crisis center, and even if they press 1, or 2, or 3, being able to link to local resources is of course always important. So, that is something we've worked on actively at meetings with the FCC, and with the phone companies to examine potential ways forward.

Dr. Ramya Sundararaman:

Very interesting, Richard. Thank you. So, when we encounter someone in crisis, what steps can we take to offer support?

Dr. Richard McKeon:

Well, there are a couple of things that I think are really important when you encounter someone who's in crisis or appears to be in crisis. One is to be willing to ask the person if they're having thoughts about suicide. I think that's really important, but oftentimes people will shy away from doing that because they don't know what the answer will be. And if the person says yes that they're suicidal, it'd be very anxiety-provoking for the person asking the question if they don't know what to do in response, or that person may be afraid they'll actually make things worse or put the idea in the person's head. It's very clear that asking somebody whether they're having thoughts about suicide is not going to put the thought in their head, and it is also not going to make things worse.

If anything, sometimes people can be very isolated with their thoughts about suicide, and asking about it gives the person an opportunity to acknowledge their thoughts about suicide and to not be so isolated and be able to have a connection with another person. Then what becomes important is how to help the person get the help that they would need. So, letting people know about the availability of 988 is one important thing that anyone can do. The encouragement for someone to talk to if they have it, if they're connected to mental health care, to make sure that they are talking about this with their therapist or psychiatrist if they have one or with their primary care doctor. So, the things that I would emphasize are being willing to ask whether somebody is having thoughts about suicide, and then being able to listen to what the person has to say, to not panic. Not everyone who has thoughts about suicide, for example, needs to be rushed to an emergency room, but you do want to inquire about do they know where to get help. Telling them about 988 is important and potentially assists them in linking to other help or resources.

Dr. Ramya Sundararaman:

Absolutely, Richard. Yep. My next question is about self-care, something that all of us providers are quick to ignore for ourselves, but in thinking about post-responders and those who might be supporting someone in crisis, what are some strategies they can use to take care of themselves?

Dr. Richard McKeon:

So, I think that there are a number of things that are important, certainly for people who work on the hotlines or in other crisis services like mobile crisis. One of the things that happens is that they have repeated exposure to suicidal people and to stories around that. So, they need support for having a place to talk about what they are hearing, and this can take place in supervision or peer supervision groups. The Lifeline has recommendations for supervision that people should get, particularly for acute situations where a decision may need to be made about whether to send emergency intervention a decision with life-and-death consequences. More broadly when you look at public safety, one of the things that we know, for example, is that police officers and emergency medical technicians have significant exposure not only to suicidal thoughts but to death by suicide, and this traumatic exposure can potentially increase risk.

So, again, being able to provide the needed support for those who are doing this work becomes really important and to be able to recognize the impact of traumatic experiences and whether it's in the field, like when the police respond, or EMS responds, or a mobile crisis team responds, or it's on the phone where there can also be traumatic experiences for the people answering the calls. Not that every call is traumatic, and in fact many people who work the lines find the work to be deeply gratifying, but there are occasions that some calls may be traumatic, and so the responders definitely need support.

Dr. Ramya Sundararaman:

Absolutely. Thanks, Richard. Is there a memorable story you would like to share with our listeners about how call centers help those who call 988?

Dr. Richard McKeon:

Yeah, sure. I think that there are a number of them that come to mind, but in general, the approach of the call responder is to listen, to make what's called good contact, right? So that if somebody's in crisis, they don't want somebody who's responding robotically, right, according to some script, but rather they want to feel like the person is really listening to them and listening to their story about how they're doing and how they got to the point where they are at the moment of the call. So, one part of it is active listening, making good contact with the person so they can feel understood, but then also to engage in problem-solving with them. So, not only does the person feel understood, but whatever challenges that they are facing, and problem solve with them potential ways of moving forward. In dialectical behavior therapy, they talk about radical acceptance. There are things that can't be changed, so coming to acceptance of them, but there are also things that can be changed. This can range from having disrupted sleep, improving the sleep cycle can improve suicidal ideation, to all kinds of others. There could be issues around food, around housing, and so forth. Where the knowledge of local resources becomes important.

But one story that sticks in my mind, which happened a couple of years ago, was that a call came into Rocky Mountain Crisis Partners in Colorado of a person who was very much at imminent risk for suicide, but the call came in the middle of a blizzard up in the mountains. So, while ideally, you would've wanted to have sent a mobile crisis team to the site, the blizzard up in the mountains prevented access. Well, the call responder spent literally hours, I think like 10, 12 hours on the phone with the person keeping them talking, keeping them connected before help could get to them, and that the person ultimately survived.

So, to me, that was a very dramatic example. And call responders also do things like deal with the issue of access to lethal means because that's a key factor in whether somebody dies by suicide or not. It's one of the reasons that safe storage of firearms or of medications is so important because sometimes just getting through a short period of time, the crisis intensity could begin to abate some after 10, 20, or 30 minutes at times. And sometimes the difference between life and death is whether there is immediate access to lethal means. So again, that's part of the reason that safe storage of firearms, for example, is so important. In fact, the Suicide Prevention Resource Center is currently working on an adaptation that we expect to come out next year on adapting the current calm curriculum counseling on access to lethal means, which is an online course specifically for crisis call responders.

Dr. Ramya Sundararaman:

Thanks, Richard. I certainly appreciate everything that the call responders do. My next question is about some people worrying that they may be judged if they reach out for help. How can we reduce the stigma around seeking medical health support?

Dr. Richard McKeon:

That's a great question, and I think that there are multiple facets to that. Sometimes people do feel uncomfortable reaching out for help. I think this is a particular concern among men, although certainly, it's a concern for some women as well. To encourage them to be willing to ask for help, and that it's not a weakness to be reaching out for help. We all have to depend on each other. So, I think that things like public service announcements really reinforce that it's okay to ask for help, it's okay to depend on each other. I think that's one reason that, and I think you're very well aware of this Ramya, that depending on your buddies is so important in the military. Men are all so used to the idea that you'll have to depend on each other in various occupations, or in sports, that no one person can do it alone. So, that's a really important message. I think the other piece to it has to do with people's potential concerns about the mental health system, and that's where it becomes so important to make the mental health system accessible and also to reduce reliance on coercive means. In some ways, one of the challenges in the crisis system that SAMHSA is very much focused on working to transform, is that in many places the system is designed to get people to emergency rooms, or worse, people may become incarcerated when they have a mental health condition.

And these are things that we want to be able to avoid. Of course, sometimes people need to go to emergency rooms, but we know there's a problem with emergency department boarding. It's not the ideal place, and it's not necessary for everyone who's thinking about suicide to be in an emergency room. So, our data shows that a good 80% of the time a crisis can be de-escalated over the phone, and when it's not, a mobile crisis team that can be sent without the police is part of SAMHSA's overall goal for transforming behavioral health crisis services. And so, we talk about someone to call, someone to come, and a place to go. If the mobile crisis team visit shows that the person does need more than can be provided on that mobile crisis visit, that crisis stabilization unit can be utilized as an alternative to emergency departments and inpatient hospitalization. So, SAMHSA describes this ideal system and our guidelines for National guidelines for behavioral health crisis services, which are available on the SAMHSA website, along with numerous supporting papers done by the National Association of State Mental Health Program Directors regarding how to move forward with this kind of implementation. And now every state has access to additional funding, not only through 988 but through SAMHSA's Mental block grant, which now is a 5% crisis services set aside.

Dr. Ramya Sundararaman:

All research and inspiration talking with you, Richard. My last question is how do you envision the future of mental health care and crisis support? What can our listeners do to support that vision?

Dr. Richard McKeon:

Yeah, thank you. Thank you for that question. Our vision is of a transformed behavioral health crisis system where no one falls through the cracks, where there is coordination among crisis services, and where people at risk can maintain a connection to help and not feel like they're just lost between

fragmented systems. So, the vision is of 988 call centers as the hub of a system. We talk about the air traffic control model, and what does that have to do with crisis care? Well, if someone flies from Washington to Los Angeles, there's never a time when an air traffic controller is not aware of where that plane is. We shouldn't lose Americans at risk in the gaps in our crisis systems. So, the idea of this air traffic control model is that 988 can be the hub of a transformed system and know whether somebody in crisis is waiting for a mobile crisis visit to get there, or that a mobile crisis team has recommended that somebody go to a stabilization unit.

Now, we know there's still a lot of work to do. There are too many communities that don't have mobile crisis teams now. There are a lot more than in the past because there are funding mechanisms that exist now, such as the block grant set aside. Also, an increased Federal Medicaid match is available for mobile crisis teams and The Center for Medicare/Medicaid Services is working with a number of states on this. So, we want to expand the numbering of mobile crisis teams so that when there is a need for someone to come, it can be a mobile team of mental health professionals, ideally with a peer involved in that, as opposed to having to rely on the police to do that for us. And then finally, I would say the last piece in terms of who would look forward to the future is that another major SAMHSA initiative is our certified community behavioral health clinics, which are responsible for providing rapid access to care.

Because if somebody calls 988 and they're having suicidal thoughts, if we know we can get them into care the next day, then that minimizes the likelihood of more intense measures having to be utilized. And so, we hope that 988 can also help with enhancing access, not only the crisis services but also to mental health services and addiction services more broadly. And then I will mention one other thing, another area is really the coordination between 988 and 911, and there are a number of very promising programs that exist in Houston. The Harris Center, which is the 988 Center in Houston, has people co-located in the 911 Public Safety Answering Point. In Austin, as you call 911 there's also, there's a press 1, 2, 3, and 4 option for police, medical services, and fire with press 4 being mental health. There were also programs that work on doing a warm handoff from 911 to 988, such as the DiDi Hirsch Center in Los Angeles that works with the 911 Police Communication Center to transfer calls to DD Hirsch. Similarly, in the city of St. Louis, the behavioral health response has a very similar program, and we're seeing other programs of this type in different places around the country. So, what we are hoping for is more coordinated care where people are not falling through the cracks, where they get the help, they need as quickly as they can both in their crisis care, but also for their ongoing mental health or substance use needs.

Dr. Ramya Sundararaman:

Thank you, Richard. I can't thank you enough for being here with us today and talking with us about 988 Suicide and Crisis Lifeline. Navigating a crisis is part of maximizing well-being. It's not just been a pleasure, it's always an inspiration to have you with us, and thank you for being here to talk about this important resource. To our listeners everywhere, we hope you enjoyed today's episode and that you will join us again. Have a great day.

Dr. Richard McKeon:

Take Care. Bye-bye.