
@PeacefulMindPeacefulLife
If you have the chance to make people happy, just do it. Sometimes people are struggling silently. Maybe, your act of kindness can make their day.
—@WILLESDENSTAFF

Let's Talk about Suicide

University of Arizona College of Medicine Phoenix
Department of Medicine Grand Rounds
January 24, 2020

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Chief of Staff
Phoenix VA Medical Center

Outline

1. Introduction
2. Epidemiology
3. Video—Kevin Hines
4. Risk Factors, Screening, Assessment
5. Warning Signs
6. Doctors and Suicide
7. Interventions—Video-- Upstream
8. Veterans: Arizona's Be Connected

Why Suicide? Why Talk?

- Suicide is a growing public health concern, both nationally and internationally.
- For youth, aged **10-18**, suicide is now the **second** leading cause of death!
- One doctor completes suicide in the U.S. every day -- the highest suicide rate of any profession.
- About every 12-13 minutes, someone in the US dies by suicide.

Again, Why Do We Need to Talk about Suicide?

- Every day, ~117 Americans complete suicide
- ~90% of those who complete suicide have a diagnosable psychiatric disorder at the time of death
- Economic burden is estimated to be $44B annually, with costs falling most heavily on those adults of working age.
- Among those with a mood disorder, 12-20% will ultimately die from suicide. The first three months after diagnosis is the period of highest risks. The three months following the first attempt are the highest risk for a second attempt.
- In comparing attempts and completions, 25:1 for 18yo; 100:1 for young; **4:1 for elderly.**

First, Some Statistics

2016 Statistics -- Source MMWR 10-4-2019 “Surveillance for Violent Death—National Violent Death Reporting System, 32 states, 2016” (includes AZ)

Rate :

15.7 per 100K; males 24.8 per 100K; females 7.0 per 100K

males = ~3.5 X # females

Age:

Among males, 50.4% of suicide decedents were adults aged 35-64.

Men aged ≥85 years had the highest rate (44.5 per 100K)

followed by men aged 75–84 (33.6 per 100K)

and 45–54 years (29.3 per 100,000 population, respectively)

Among females, 58.7% of suicide decedents were aged 35-64.

Statistics—Ethnicities More from MMWR

Ethnicity:

Non-Hispanic whites accounted for 82.8% of suicides

Non-Hispanic American Indians/Alaska Natives had the highest rate (28.6 per 100K)

***Males*:**

Non-Hispanic American Indian/Alaska Native males had highest rate (42.8 per 100K)

Non-Hispanic white males next highest (29.7 per 100K)

Lowest rate Asians/Pacific Islanders (12.1 per 100K)

Females:

Rates highest for non-Hispanic American Indian/Alaskan Native (15.1 per 100K) and non-Hispanic white (8.4 per 100K)

Rates lowest for non-Hispanic Black (3.0 per 100K) and Hispanic (3.4 per 100K)

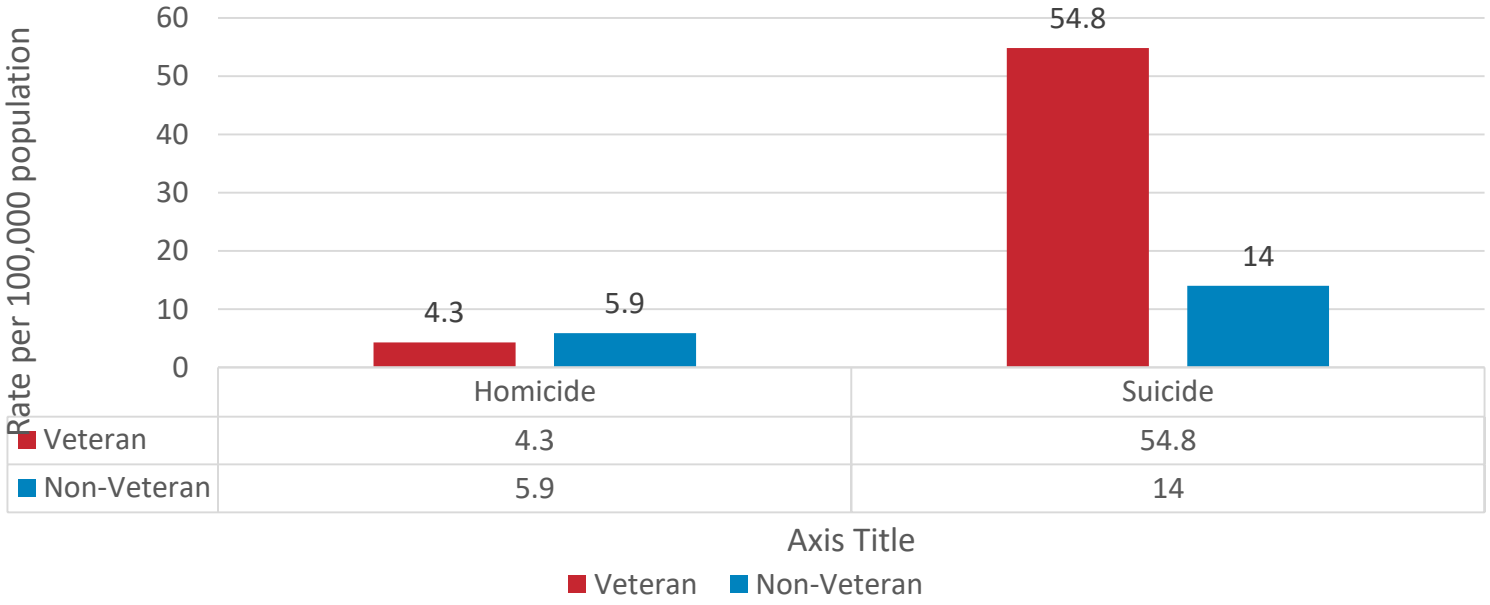
Most Frequent Means of Suicide

	US Total	US Males	US Females
Firearms	49.4%	55.3%	29.1%
Hanging/ Strangulation/ Suffocation/	7.8%/ 4.4%/ 2.3%		
Total of these	27.8%	27.7%	28.2%
Poisoning	14.4%		32.9%
Other	8.5%		

ARIZONA:
Violent Death Reporting System

Violent Death Rates by Veteran Status in Arizona, Jan 1, 2016-Dec. 31, 2016

There are an estimated 505,794 veterans residing in Arizona, according to the U.S. Census and American Community Survey 2016 estimates. For this report, we used data on 299 (22 homicides, 277 suicides) violent deaths of veterans, and 1,257 non-veteran violent deaths (370 homicides, 887 suicides).



Contact Charles M. Katz (ckatz@asu.edu) or David E. Choate (dchoate@asu.edu) for more information about the AZ-VDRS.

AZ Veteran Suicide Deaths 2014

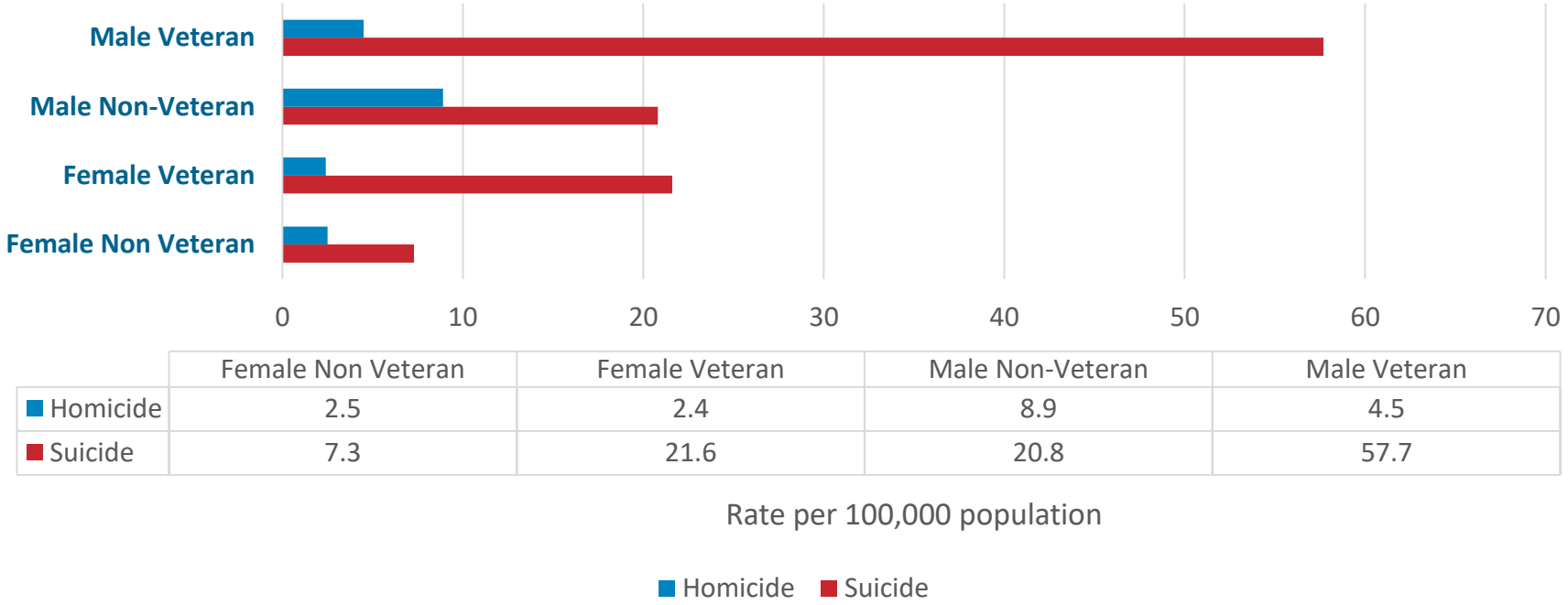
Sex	AZ Veteran Suicides
TOTAL	259
Male	247
Female	12

Age Group	Total AZ Vet Suicides	Total Western Region Vet Suicides	Total National Vet Suicides	AZ Vet Suicide Rate per 100K	Western Region Vet Suicide Rate	National Vet Suicide Rate
TOTAL	259	1970	7388	53.6	45.5	38.4
18-34	30	276	1171	76.8	64.7	70.4
35-54	78	559	2193	74.5	56.0	47.7
55-74	93	692	2594	42.4	35.9	30.4
75+	58	443	1430	48.3	45.2	32.0

After accounting for differences in age, the Veteran suicide rate in Arizona was significantly higher than the national Veteran suicide rate (p=0.0009).

AZ: Violent Death Reporting System

Homicide & Suicide Rate per 100,000 by Veteran Status and Sex, AZ 2016



	Female Non Veteran	Female Veteran	Male Non-Veteran	Male Veteran
Homicide	2.5	2.4	8.9	4.5
Suicide	7.3	21.6	20.8	57.7

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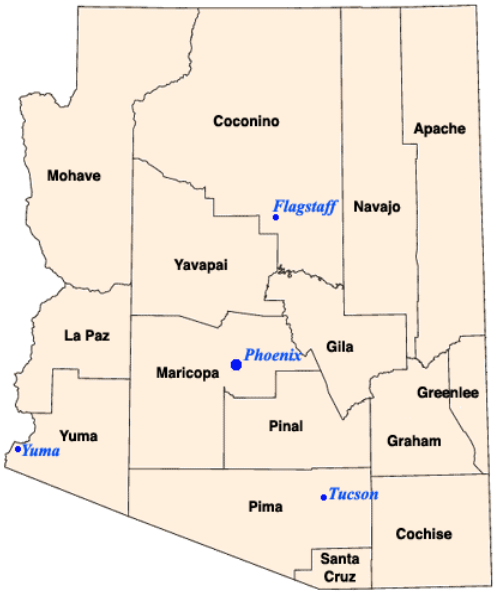
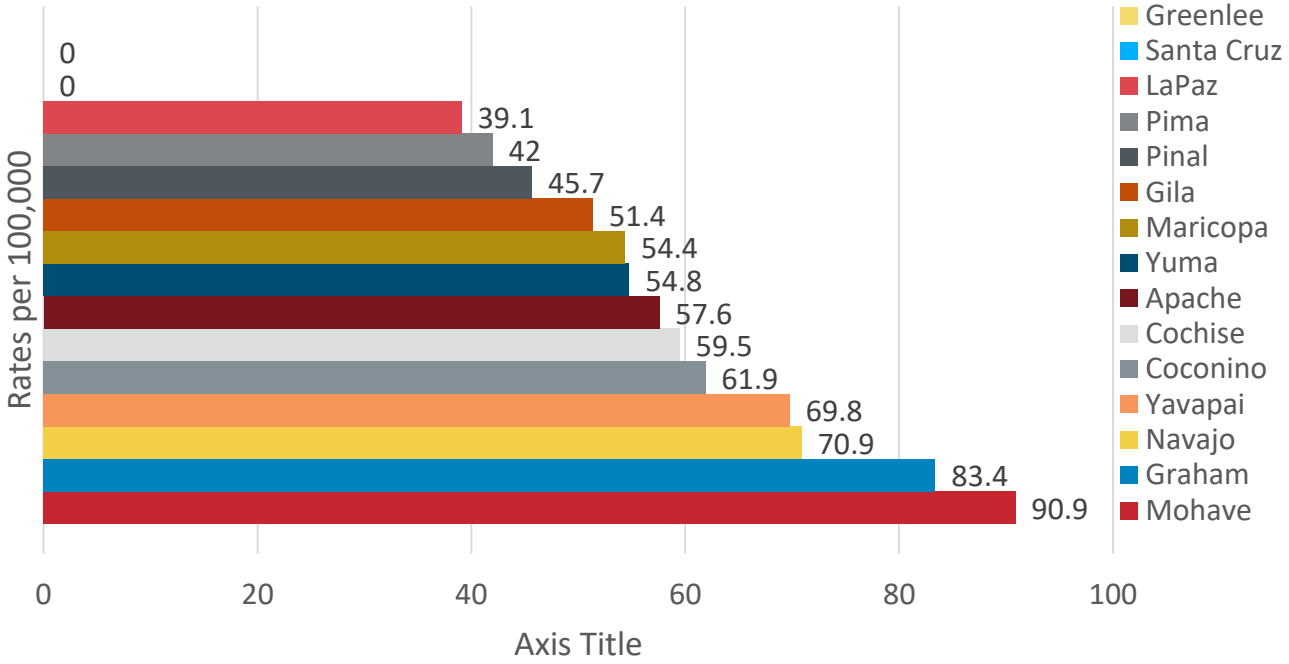
AZ: Violent Death Reporting System: Suicide Rates per 100,00 Population among Veterans by County 2016





- The statewide average rate per 100,000 population for veteran suicides in Arizona is 54.8 (n=277).
- Greenlee and Santa Cruz counties had no veteran suicides, and La Paz, Pima and Pinal had low rates of veteran suicide.
- Mohave, Graham, Navajo and Yavapai counties all have suicide rates well-above the Arizona average rate.

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VA Data: Comparing Veteran and Overall Suicide Rates

Age Group	AZ Vet Suicides	AZ Total Suicides	W Region Total Suicides	Nat'l Total Suicides	AZ Vet Suicide Rate	AZ Suicide Rate	W Region Suicide Tate	Nat'l Suicide Rate
TOTAL	259	1207	1749	41425	53.6	23.7	18.8	17.0
18-34	30	307	2774	10732	76.8	19.7	15.3	14.5
35-54	78	417	3873	15473	74.5	24.9	19.7	18.4
55-74	93	367	3041	11637	42.4	25.9	20.3	17.5
75+	58	116	1061	3583	48.3	25.9	24.9	18.1

After accounting for differences in age, the Veteran suicide rate in Arizona was significantly higher than the overall national suicide rate (p=<.0001).

Nationally, for the 41K deaths by suicide each year, over 200,00 others are affected by the loss of a loved one or acquaintance.

Arizona Veteran and Overall Arizona, Western Region, and National Suicide Deaths by Method, 2014

	AZ Veteran Suicides	AZ Suicides	Western Region Suicides	National Suicides
Firearms	73.0% (189)	55.4% (669)	46.8% (5026)	50.2% (20,801)
Suffocation	14.3% (37)	22.9% (277)	26.7% (2869)	25.9% (10730)
Poisoning	-	16.2% (196)	17.9% (1927)	16.3% (6734)
Other	-	5.4% (65)	8.6% (927)	7.6% (3160)
Other, poisoning	12.7% (33)	-	-	-

Doctors and Suicide

General Public Rate of Suicide: 12.3 per 100K

Doctors' Rate of Suicide: 28-40 per 100K

Means of Suicide: Poisoning and Hanging most common

Although female doctors attempt suicide far less often than women in the general population, their completion rate exceeds that of the general population by 2.5 to 4 times. It also equals the completion rate of male doctors.

Kevin Hines

"The Man who Survived Jumping from the Golden Gate Bridge." (8:59)

https://www.youtube.com/watch?v=kQ4XCNZdKfI

Is there a neuroanatomic site associated with suicidal behavior?

2 prominent regions identified by *in vivo* and in postmortem exams reveal serotonergic hypofunction in those who have died by suicide or made serious suicide attempts:

1. The dorsal and medial raphe nuclei in the midbrain, which host the main serotonergic cell bodies
2. The prefrontal cortex, especially the ventral prefrontal cortex, innervated by the serotonergic system. This can result in a breakdown in inhibitory function leading to a predisposition to impulsive and aggressive behavior.

Pathophysiology of Suicidal Behavior

- Some cases have a neurologic basis distinct from the primary psychiatric disorder.
- Alterations in the hypothalamic-pituitary-adrenal axis, serotonergic system dysfunction, and excessive noradrenergic activity are associated with suicidal behavior. Altered functioning may stem from genetic and/or developmental causes. (e.g., exposure to extreme or chronic stress in childhood, interaction of subsequent developmental consequences with genetic vulnerability)
- HPA and noradrenergic systems appear to be involved in the response to stressful events.
- Serotonergic dysfunction is thought to be trait-dependent and associated with disturbances in the regulation of anxiety, impulsivity, and aggression.

Risk Factors

- Psychiatric disorders (90% of completers have diagnosable psychiatric illness---most common are depression, bipolar illness, substance abuse, schizophrenia, and personality disorders)
- Alcohol and substance abuse disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of physical or sexual trauma or abuse, especially in childhood
- Medical illness involving the brain or CNS
- Family history of suicide
- Suicidal ideas, plans, or attempts (current or previous)
- Lethality of suicidal attempts or plans

Most Prominent Risk Factors

- Dysregulated impulse control
- Propensity to intense psychologic pain that includes hopelessness, often in the context of a mood disorder

Believed to reflect Serotonergic System dysregulation.

Protective Factors for Suicide

- Access to effective clinical care for mental, physical, and substance use disorders, and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connection to family and community support
- Emotionally supportive connections with medical and mental health providers
- Effective problem-solving and conflict –resolution skills
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Reality testing ability
- Pregnancy, children in the home, or sense of family responsibility
- Life satisfaction

Major Depression and Suicide

- 20% lifetime risk of completion
- 30% of patients attempt
- >60% of completers are clinically depressed at time of death; 75% if both alcoholic and depressed
- For those 18yo+ who experience depression in the past year:
  - 56.3% thought it would be better if they were dead during their worst or most recent episode
  - 40.4% contemplated suicide
  - 14.5% made a serious plan
  - 10.4% attempted suicide

Heightened risk for suicide in those who are depressed with:

- Extreme hopelessness or depression
- A lack of interest in previously pleasurable activities
- Intense anxiety/panic attacks
- Insomnia
- Talk of suicide or history of attempts
- Irritability, agitation, or enraged behavior
- Isolation

Other psychiatric conditions

Condition	
Bipolar Disorder	1 in 5 die from suicide; treatment reduces risk
Alcohol and Substance Abuse	Risk is 50-70% higher than general population; Alcohol is a factor in 30% of suicides; 7% of those with alcohol dependence die by suicide. **Not clearly causal**—substance abuse and suicide may be responses to the same pain
Schizophrenia	Young, unemployed men at highest risk; risk highest in early stages of illness, early relapse, and early recovery. Risk factors include recurrent relapses, suspiciousness and delusions, and depressive symptoms
Personality Disorders	20-50% of young people who complete suicide have a diagnosable personality disorder. Borderline and antisocial personality disorders are most frequently associated with suicide. Histrionic and narcissistic personality disorders and traits including impulsivity and aggression are also associated

Risks from Co-Morbid Medical Disorders

- Illnesses affecting the brain and CNS have a greater effect on suicide risk compared to other medical conditions. Examples include epilepsy, AIDS, Huntington's disease, traumatic brain injury, and cerebrovascular accidents.
- Non-CNS cancer and other potentially fatal conditions carry a more modest risk.

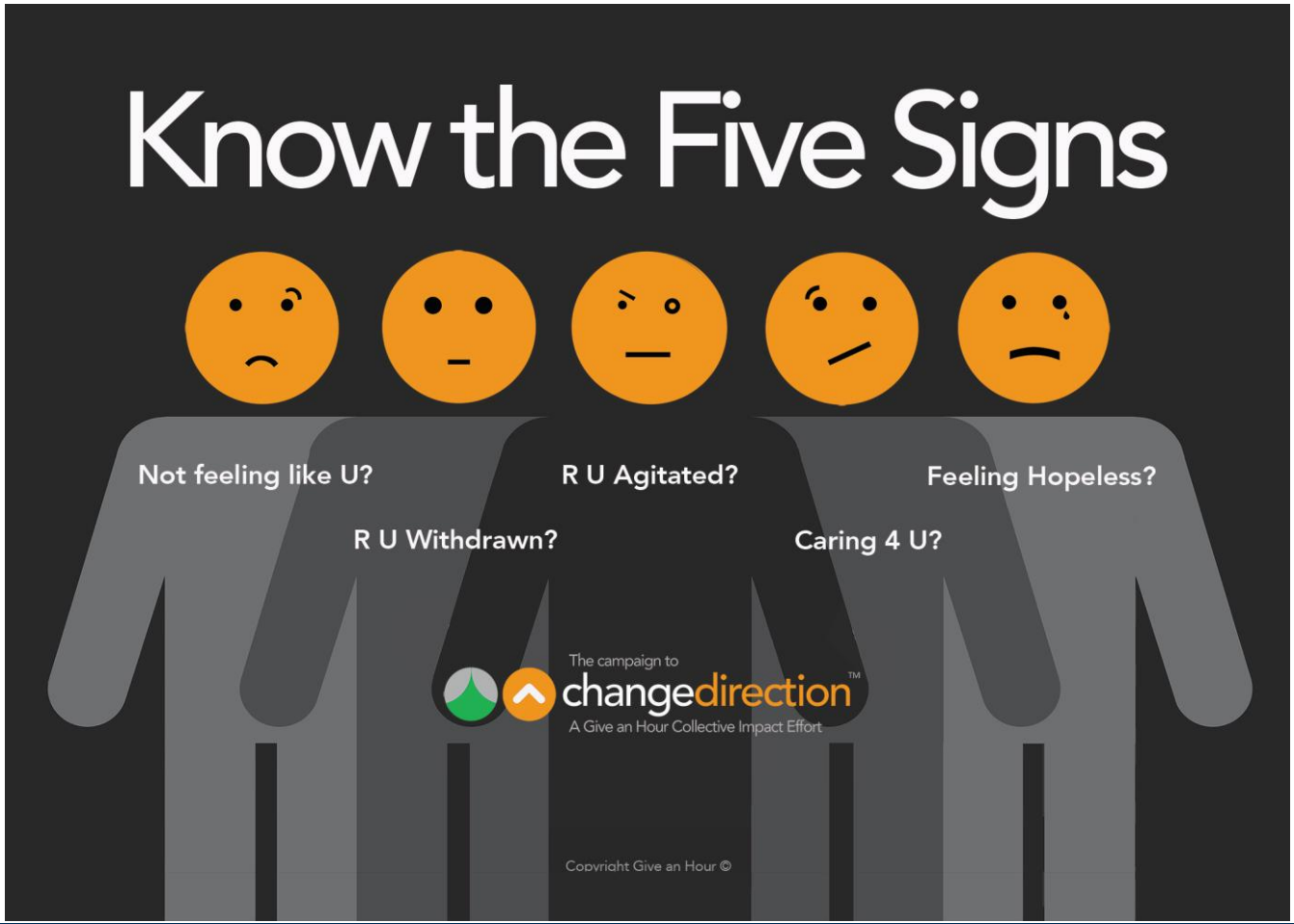
Imminent Suicide: Any Hints?

- Trigger: possibly a distressing event---loss of a loved one or career failure
- "Depression plus"

  desperation, rage, psychic pain, inner tension, anxiety, guilt, hopelessness, acute sense of abandonment

  Changes in behavior or speech, including indirect speech, or talking as if saying goodbye or going away, purchasing a gun, suddenly putting one's affairs in order, deterioration in social or occupational functioning, increasing use of alcohol, other self-destructive behavior, loss of control, rage explosions

5 Signs of Emotional Suffering



Warning Signs

- Observable signs of serious depression, such as unrelenting low mood, pessimism, hopelessness, desperation, anxiety, psychic pain, inner tension
- Withdrawal from friends and/or social activities
- Sleep problems
- Loss of interest in personal appearance, hobbies, work/school

Warning Signs--continued

- Increased alcohol or other drug use
- Recent impulsiveness and taking unnecessary risks
- Talk about suicide, death, and/or not having a reason to live
- Making a plan; giving away prized possessions, sudden or impulsive purchase of a firearm or other means to kill oneself such as poisons or meds
- Unexpected rage, anger, or other drastic behavior change
- Recent humiliation, failure, or severe loss, especially in a relationship
- Unwillingness to “connect” with potential helpers

Additional "Hints"

Expressions of thoughts, feelings, or behaviors

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat, or work
- Can't get out of the depression
- Can't make the sadness go away
- Can't see the possibility of change
- Can't see self as worthwhile
- Can't get someone's attention
- Can't seem to get control

Mnemonic
IS PATH WARM*

Ideation
Substance Abuse
Purposelessness
Anxiety
Trapped
Hopelessness
Withdrawal
Anger
Recklessness
Mood change

*American Association of Suicidology

Prevention: Screening and Assessment of Suicide Risk

Why?

- **75%** of elderly suicide completers had visited their primary care physician in the month prior to suicide
- **45%** of all suicide completers have contact with a mental health professional in the year before their deaths
- **Only 30%** reported suicidal ideation or intent to a healthcare professional before their suicide attempt

"Primary Care providers occupy a niche in the healthcare system and have perhaps the greatest opportunity to impact suicidal persons through educational means."

Assessment

- Have you made any plans for ending your life?
- How are you planning to do it?
- Do you have in your possession the means to do it (pills, guns, other means)?
- Have you considered when to do it?

Increased risk: more thought, specific plans, intention to act on plans.

- Have you ever thought life was not worth living?
- Did you ever wish you could go to sleep and just ot wake up?
- Is death something you have thought about recently?
- Have things reached the point that you have thought of harming yourself?

Risk of Suicide Attempt	Indicators of Suicide Risk	Contributing Factors	Initial Action Based on Level of Risk
High Acute Risk	Persistent suicidal ideation or thoughts Strong intention to act or plan Not able to control impulse Recent suicide attempt or preparatory behavior	Acute state of mental disorder or acute psychiatric symptoms Acute precipitating event(s) Inadequate protective factors	Maintain direct observational control of the patient Limit access to lethal means Immediate transfer with escort to urgent/emergency care setting for hospitalization
Intermediate Acute Risk	Current suicidal ideation or thoughts No intention to act Able to control the impulse No recent attempt or preparatory behavior or rehearsal of act Existence of warning signs or risk factors and limited protective factors Refer to behavioral health provider for complete evaluation and interventions Contact behavioral health provider to determine acuity of referral Limit access to lethal means	Current suicidal ideation or thoughts No intention to act Able to control the impulse No recent attempt or preparatory behavior or rehearsal of act Existence of warning signs or risk factors and limited protective factors Refer to behavioral health provider for complete evaluation and interventions Contact behavioral health provider to determine acuity of referral Limit access to lethal means	Current suicidal ideation or thoughts No intention to act Able to control the impulse No recent attempt or preparatory behavior or rehearsal of act Existence of warning signs or risk factors and limited protective factors Refer to behavioral health provider for complete evaluation and interventions Contact behavioral health provider to determine acuity of referral Limit access to lethal means
Low Acute Risk	Recent suicidal ideation or thoughts No intention to act or plan Able to control the impulse No planning or rehearsing a suicide act No previous attempt Existence of protective factors and limited risk factors Consider consultation with behavioral health to determine need for referral and treatment Treat presenting problems Address safety issues Document care and rationale for action	Recent suicidal ideation or thoughts No intention to act or plan Able to control the impulse No planning or rehearsing a suicide act No previous attempt Existence of protective factors and limited risk factors Consider consultation with behavioral health to determine need for referral and treatment Treat presenting problems Address safety issues Document care and rationale for action	Recent suicidal ideation or thoughts No intention to act or plan Able to control the impulse No planning or rehearsing a suicide act No previous attempt Existence of protective factors and limited risk factors Consider consultation with behavioral health to determine need for referral and treatment Treat presenting problems Address safety issues Document care and rationale for action

Specifically about Doctors

- Most common diagnoses in doctors who complete suicide are mood disorders, alcoholism, and substance abuse.
- One study showed that depression affects an estimated 12% of male doctors and up to 19.5% of female doctors, a rate similar to the general population. Depression is more common in medical students and residents. About 15% to 30% have symptoms of depression.
- Mood disorders among health care professionals are not restricted to North America. Studies from Finland, Norway, Australia, Singapore, China, and elsewhere have shown an increase in anxiety, depression, and suicidal thoughts among medical students and health care professionals.
- Stigma is a major obstacle to seeking medical treatment. One 2016 study found 50% of female doctors who completed a Facebook questionnaire reported meeting criteria for a mental disorder but were reluctant to seek professional help because of the fear of stigma.

What Contributes to the Risk for Doctors?

- Beth Brodsky, PhD, associate clinical professor of medical psychology in psychiatry at Columbia University and the Irving Medical Center, New York, calls the high rate of doctor suicide "alarming," but not surprising, given the stress doctors face.
- The stress starts in medical school and continues in residency with the high demands, competitiveness, long hours, and lack of sleep. This may contribute to substance abuse, another risk factor for suicide.
- This high stress is made worse by dwindling healthcare resources and residency positions, she says. When medical students graduate and enter the profession, they face different but equally challenging stressors.
- As more women enter the medical profession, they are becoming increasingly vulnerable to the fallout from work stressors. As a result, their rate of suicide is also increasing, Brodsky says.

Prevention of Suicide: Doctors

- Brodsky is among the experts advocating for better ways of addressing stress, which may start with simple changes. She notes that suicide is an "illness and not a crime."
- Openly discussing suicide as an illness helps to "bring it out of the darkness" and shed the stigma shadowing this problem.
- Michael Myers, MD, wrote: “September 17, 2019 was the second annual National Physician Suicide Awareness Day.”
- Created by the Council of Residency Directors in Emergency Medicine (and many of its affiliated groups), the goal is to lessen the stigma and encourage physicians and all other clinicians to speak about their struggles either privately or openly—and seek help. The group’s founder and director, Loice Swisher, MD, FAAEM—in partnership with the American Association of Suicidology—produced a daylong series of interviews and podcasts with experts in physician health and suicide.
- On September 17, Steve Moffic, MD wrote an impassioned piece “Being Our Colleagues’ Keepers: Preventing Our Suicides”.
- The American Hospital Association (AHA) in partnership with the Education Development Center (EDC) and its Suicide Prevention Resource Center produced a state-of-the-art podcast called “Be Well: Preventing Physician Suicide” which was released and posted the week before National Physician Suicide Awareness Day.

Fight Stigma

1. Talk Openly About Mental Health.
2. Educate Yourself and Others.
3. Be Conscious of Language.
4. Encourage Equality Between Physical and Mental Illness.
5. Show Compassion for Those with Mental Illness.
6. Choose Empowerment Over Shame.
7. Be Honest About Treatment.
8. Let the Media Know When They're Being Stigmatizing.
9. Don't Harbor Self-Stigma.

9 Ways to Fight Mental Health Stigma | NAMI: National Alliance for the Mentally Ill

www.nami.org/Blogs/NAMI-Blog/October-2015/9-Ways-to-Fight-Mental-Health-Stigma

Resources for All of Us– p. 1/2

- **UArizona College of Medicine Phoenix: Students, residents, fellows:**

Director of GME and UME Wellness Daniel Drane
https://wellness.arizona.edu/residentsfellows/resources-residentsfellows

- **Banner University Medical Center Phoenix**

Banner Health Employee Benefit: Employee Assistance Program

https://www.glassdoor.com/Benefits/Banner-Health...

Glassdoor is your resource for information about the Employee Assistance Program benefits at Banner Health. Learn about Banner Health Employee Assistance Program, including a description from the employer, and comments and ratings provided anonymously by current and former Banner Health employees

Resources for All of Us—p. 2/2

- **University of Arizona College of Medicine—Phoenix**

https://lifework.arizona.edu/counseling-coaching/employee-assistance-counseling

Call (520) 621-2493 to schedule an appointment

- **Phoenix VA Health Care System**—click to EAP on homepage

POINT OF CONTACT: Consuelo Fiel

Everyone has personal problems from time to time. Your EAP offers professional, confidential counseling and consultation that can help you resolve these issues. To obtain services or for more information, call us toll-free at 800.869.0276. EAP is available 24 hours per day, 7 days per week to assist you.

It occurred to Pooh and Piglet that they hadn't heard from Eeyore for several days, so they put on their hats and coats and trotted across the Hundred Acre Wood to Eeyore's stick house. Inside the house was Eeyore.

"Hello Eeyore," said Pooh.

"Hello Pooh. Hello Piglet," said Eeyore, in a Glum Sounding Voice.

"We just thought we'd check in on you," said Piglet, "because we hadn't heard from you, and so we wanted to know if you were okay."

Eeyore was silent for a moment. "Am I okay?" he asked, eventually. "Well, I don't know, to be honest. Are any of us really okay? That's what I ask myself. All I can tell you, Pooh and Piglet, is that right now I feel really rather Sad, and Alone, and Not Much Fun To Be Around At All. Which is why I haven't bothered you. Because you wouldn't want to waste your time hanging out with someone who is Sad, and Alone, and Not Much Fun To Be Around At All, would you now."

Pooh looked at Piglet, and Piglet looked at Pooh, and they both sat down, one on either side of Eeyore in his stick house.

Eeyore looked at them in surprise. "What are you doing?“

"We're sitting here with you," said Pooh, "because we are your friends. And true friends don't care if someone is feeling Sad, or Alone, or Not Much Fun To Be Around At All. True friends are there for you anyway. And so here we are."

"Oh," said Eeyore. "Oh." And the three of them sat there in silence, and while Pooh and Piglet said nothing at all; somehow, almost imperceptibly, Eeyore started to feel a very tiny little bit better.

Because Pooh and Piglet were There.

No more; no less.

Specifically about Veterans

Protective Factors

- Strong interpersonal bonds when serving
- Responsibilities/duties to others
- Steady employment
- Sense of belonging/identity
- Access to health care
- In one study, having a service connected disability (?>access to health care?)
- Trends: age, African/American, admission to a nursing home

Risk Factors

- Combat exposure
- Combat wounds
- PTSD with other MH problems (PTSD alone +/-)
- Comorbid major depression
- TBI
- Poor social support
- Feelings of not belonging or being a burden to society
- Acquired ability to inflict lethal self-injury
- Access to lethal means
- Loss of rank, disciplinary action, command/leadership stress, transfers, separation from unit

Prevention: Veterans

- Project REACH VETS: Predictive Modeling and Concentration of the Risk of Suicide (62 variables, statistical risk)
- Suicide Prevention Coordinators
- Suicide Risk Assessments
- Behavioral Health Autopsies
- Veterans Crisis Line (1-800-273-8255 *1)
- Arizona's Be Connected Program (1-866-4AZ-VETS)

Combined VA-DOD Recommendations for Veterans and Active Duty Service Members

- Providers should take reasonable steps to limit the disclosure of protected health information to the minimum necessary to accomplish the intended purpose.
- Providers should involve command in the treatment plan of service members at high acute risk for suicide to assist in the recovery and the reintegration of the patient to the unit. For service members at other risk levels, the provider should evaluate the risk and benefit of involving command and follow service department policies, procedures, and local regulations.
- When performing a medical profile, the provider should discuss with command the medical recommendation and the impact on the service member's limitations to duty and fitness for continued service.
- Providers should discuss with service members the benefit of having command involved in their plan and assure them their rights to protected health information, with some exceptions, regarding to the risk for suicide.
- As required by pertinent military regulations, communicate to the service member's chain of command regarding suicidal ideation along with any recommended restrictions to duty, health and welfare inspection, security clearance, deployment, and firearms access. Consider redeployment to home station any service member deployed to a hazardous or isolated area.
- Service members at high acute risk for suicide who meet criteria for hospitalization and require continuous (24-hour) direct supervision should be hospitalized in almost all instances. If not, the rationale should specifically state why this was not the preferred action, with appropriate documentation.
- During operational deployment conditions or other extreme situations during which hospitalization or evacuation is not possible, "unit watch" may be considered as appropriate in lieu of a high level care setting (hospitalization), and service department policies, procedures, and local regulations should be followed.
- Because of the high risk of suicide during the period of transition, providers should pay particular attention to ensure follow-up, referral, and continuity of care during the transition of service members at risk for suicide to a new duty station or after separation from a unit or from military service.

U.S. Department of Veterans Affairs. VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. Available at http://www.healthquality.va.gov/guidelines/MH/srb

Resources for Veterans

1. The Veterans Crisis Line, at 800-273-8255*1, is free to all active service members, including members of the National Guard and Reserve, and veterans, even if they are not registered with the VA or enrolled in VA Health care

Available at https://www.veteranscrisisline.net

Please add this phone number to your contacts on your cell phone.

Resources for Veterans

2. In Arizona, Veterans, Families, Service Members and Community Members can also reach out:

Connect to BeConnectedAZ.org or call

866-4AZ-VETS

Please take a minute to put these contacts in your cell phone.

Be Connected:
Working Upstream from the Acute Phase

What do we mean about working upstream?

https://www.youtube.com/watch?v=ilk_pLDY7TQ&t=2s

be connected
service members • veterans • families • communities

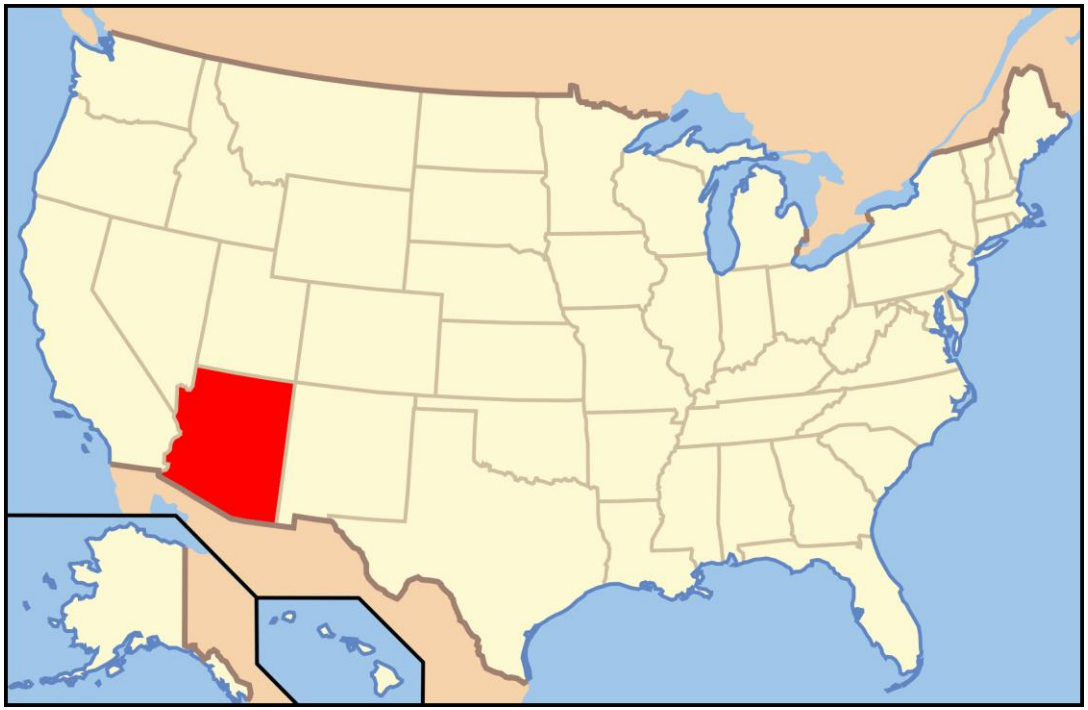
Be Connected: Breaking Down Silos and Building Up Our Community for Suicide Prevention

- Built on a model that reduced AZ National Guard Suicides from highest in the nation to zero, for three years.
- Navigators connect Veterans with vetted Resources to address needs.
- Analysis of first year's calls: Calls were about social determinants of health.

Arizona's Clay Hunt Act Initiative to prevent Veteran suicide

The Clay Hunt Suicide Prevention for American Veterans Act (SAV) was signed into law in February 2015.

Arizona added as a pilot program state in 2016.



Be Connected is Arizona's pilot program for the SAV.

Be Connected launched in April 2017.

Collective Impact Partnership among State, Federal, Nonprofits, Veterans Service Organizations, developed as a special pilot under the Clay Hunt Act, sponsored by our late Sen. McCain.

Be Connected Goals

There are three goals for the Be Connected program:

- Reduce deaths by suicide in Arizona's population of service members and veterans.
- Build upon existing capacity and strengths within our service systems, adding a new layer of coordination and support.
- Demonstrate effectiveness and develop a sustainability plan that builds program components into systems and funding.

ARIZONA MODEL: Collective Impact

ABILITY TO REACH, ENGAGE AND INTERVENE WITH SERVICE MEMBERS, VETERANS & FAMILY MEMBERS STATEWIDE

BE CONNECTED PROGRAM COMPONENTS

24/7 SUPPORT LINE	RESOURCE NETWORK	TRAINING
(All individuals, families and helpers)	(Asset mapping & resource matching – 3000+ navigators)	(In-person and online statewide)

ENGAGEMENT OF ALL KEY STAKEHOLDERS ACROSS SECTORS

MILITARY	GOVERNMENT	COMMUNITY
(Active duty, Guard, Reserve)	(Federal, Tribal, State, Local)	(Nonprofit, Faith-Based, Corporate)

STATEWIDE PUBLIC/PRIVATE PARTNERSHIP

The Be Connected support line is for everyone:
Those who need help and those who are helping

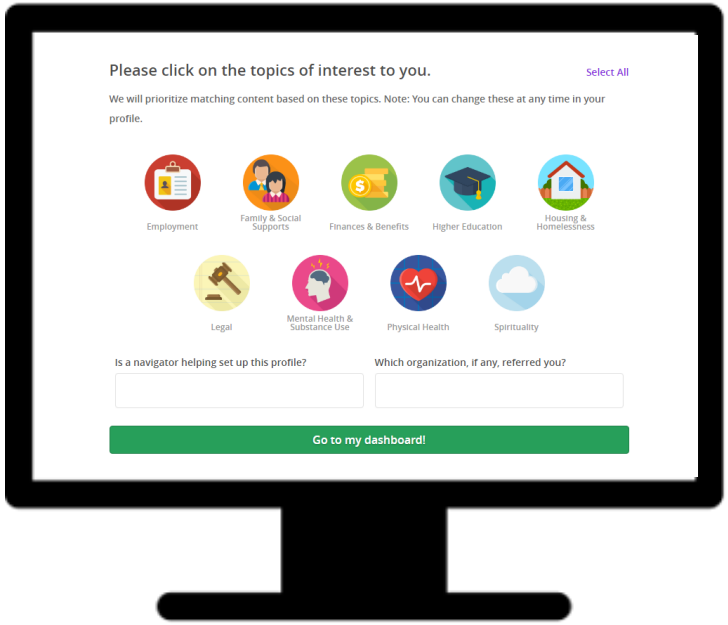
Some reasons a community member may call 866-4AZ-VETS:

- A caller needs help finding resources for his/herself, a family member or someone they are helping
- A caller is concerned about a friend/family member who struggling and the caller is not sure what, if anything, should be done next
- A caller is seeking guidance on how to support a friend/family member who is encountering barriers to treatment and support
- A caller feels overwhelmed by services and/or how to access those services
- A caller wants to be better equipped to help the community and is unsure how to get involved

MATCH

Personalized Resource Matching & Navigation

Be Connected offers tools to find the right resource at the right time:
www.ResourceCommand.org



LEARN

Training and skills to equip yourself to help

Be Connected offers training statewide, in person and online, to equip everyone in our community to help

Military/Veteran Resource Navigator | Suicide Prevention | Military Culture
Over 100 online courses | Annual Statewide Symposium

Be Connected

- >4500 Navigators trained across AZ, including bus drivers, librarians, bartenders, Veterans service Organization members, and many partners in health care and public service
- >2000 vetted resources to match to Veteran's needs
- ~7 calls first month, >1400 calls first year, now >7500 calls
- Partnered in Governors' and Mayors' Challenges to Prevent Suicide
- Awarded VA Community Partnership Award 2018

Questions?

Let’s Talk….

Thank You!