Christine Yu Moutier, M.D.:
There is now a host of research that informs that it's not a one-cause effect, really in any one instance of an individual suicide or suicidal behavior, it's always multiple risk factors that come together. But if we at least understand that there are a number of things that we, as a society, can become better about recognizing, we can make strides in preventing suicide.

LuAnn Heinen:
That's Christine Yu Moutier, chief medical officer of the American Foundation for Suicide Prevention. Difficult lived experience led her to dedicate her career to fighting this leading cause of death as a clinician, researcher, and advocate for implementing known and effective prevention strategies. She's testified before Congress, presented to the White House, and provided Congressional briefings on suicide prevention. Dr. Moutier received her medical degree and training in psychiatry at the University of California San Diego.

I'm LuAnn Heinen, and this is the Business Group on Health podcast, conversations with experts on the most important health and well-being issues facing employers. My guest is psychiatrist, Christine Yu Moutier. We're talking about factors that can increase suicide risk, who's most vulnerable, important actions employers can take for prevention, and what gives her hope for the future.

Dr. Moutier, I'm so glad you're here today. Thank you for joining us.

Christine Yu Moutier, M.D.:
Thanks for having me LuAnn. It's a pleasure.

LuAnn Heinen:
I have to ask you first how you came to this important, but really extraordinarily difficult work.

Christine Yu Moutier, M.D.:
Well, you know, as a psychiatrist, it is interesting that in my own personal history, it was actually more about my own lived experience as a medical student having struggled and then fast forward a few years later in my career was realizing that these issues are very pervasive of mental health experiences and human struggle, if not suicidal struggles amongst the fellow medical students and residents and faculty. Then several years later, by the time I was Dean for Medical Education and Student Affairs, where I was in an academic medical center, it had become clear that there were suicide losses going on, meaning colleagues across all different specialties, faculty physicians, who were taking their lives, and it was a total of 13 tragic losses over a period of 15 years at UCSD, that by that time, my own personal experience combined with my training as a psychiatrist, and then my interest in making a difference in the culture and really that true question of what does a learning environment or a work environment have to do with an individual or a population's suicide risk or protection. I was put in charge of developing some resources and programs for the UCSD health science community. This was now going back about 15 years. It was a very personal journey, much more so than having a professional interest from the standpoint of patient care, let's say.

LuAnn Heinen:
Wow, that was a lot. It does remind me that even before COVID, we've seen in the professions, highly-trained professional, skilled people like physicians and lawyers, surprising rates of death by suicide.

Christine Yu Moutier, M.D.:
Yes, so really the silver lining in all of that experience was that there was the opportunity to develop a new program that had really not been done at this time. It was like 2005, 2006, we were digging deep to find resources and models to really try to address suicide prevention with an entire workforce and trainee

population in an academic medical center. What has happened is tremendous and is still going strong. What I'm talking about is the University of California San Diego School of Medicine and health system HEAR program, which stands for Healer Education, Assessment and Referral (HEAR). Over that length of time, as mentioned, there were 13 losses to suicide the 15 years pre the HEAR program, and there's been 1 suicide in the 15 years since its launch, and many other changes of engagement with mental health professionals, peer support programs, the rates of help seeking went way up, and lots of different outcomes that relate to that UCSD HEAR program. We've actually published on it a number of times, and it really does serve as a model that you can get a program going, it can start out kind of simple in the beginning, and it can evolve over time, which has happened at UCSD. It started out with just the physicians, residents, and medical students, but has expanded to pharmacy students and nursing staff and nursing students, as well.

LuAnn Heinen:
I want to talk about the why just a little bit, because we know survivors, and I would count you as one of those, struggle with the why. Is there more light you can shed on this? Whether it's someone for me, who I read about in the press, or a distant family member a couple generations back who allegedly died by suicide, or one of my favorite authors, Virginia Woolf, or an Anthony Bourdain. It's so confusing to understand what goes on.

Christine Yu Moutier, M.D.:
I know it really is a challenge and I think what we're seeing from the national suicide prevention space, where I now feel that I'm fortunate to kind of live and breathe 24/7 now, and at AFSP (American Foundation for Suicide Prevention), since we are the leading private funder of all suicide and suicide prevention science, there is a lot more scientific effort going on to understand what drives a person, not only to become suicidal, because suicidal thoughts are actually very commonplace in the general population, but moving into actually acting on those thoughts into suicidal behavior and death by suicide. There is now a host of research that informs that it's not a one-cause effect really in any one instance of an individual suicide or suicidal behavior. It's always multiple risk factors that come together, almost like a perfect storm. If you picture the way that certain risk factors are oftentimes longstanding and we don't even think about them as such. For example, an early history of trauma, neglect, or abuse. Some genetic loading for suicide specifically, there's now some evidence that shows that there are genetic risk for suicide that even runs separate from genetic risk for, let's say, a mood disorder or another psychiatric condition. Then there's real life happening for all of us and stressors. We have such a host of traits going on and risk factors, so that even things like when we're thinking about high achieving professionals or high achieving students, that when you have a lot of drive, but when sometimes that drive comes along with a level of perfectionism or sort of rigid thinking, almost bordering on what can be unbeknownst to the person even, as really punitive thinking, a cognitive style that holds ourself to a level that's almost impossible to achieve, and that we wouldn't hold anybody else to, for example. That's just one type of risk factor, but there are a host of these that tend to come together.

It's really hard as a suicide loss survivor. First of all, we don't have insights into all of those levels and layers of potential risk factors that had culminated in that person's untimely death or suicide attempt. But if we at least understand that there are a number of things that we, as a society, can become better about recognizing, we can make strides in preventing suicide. It's never meant to heap more guilt on the shoulders of a suicide loss survivor, because we are all doing the best that we can with the knowledge that we have and the data that's coming in at any given time. Life is a learning process and certainly because now we have more scientific knowledge about suicide risk and prevention, we can do more. Again, I have a special word of just empathy and compassion for suicide loss survivors, not to add additional sense of burden in terms of their own sense of responsibility because suicide is complex, so we won't know the what ifs, even as hard as we try looking back on all of our memories and so forth.

LuAnn Heinen:
It's complex and I really like how you're explaining it. There's no one path.

Christine Yu Moutier, M.D.:
Right, and even though the paths to suicidal behavior or suicide are heterogeneous, for sure, amongst the people who die by suicide, there are known patterns of sort of most common risk factors that emerge and interact to lead to that tragic outcome. So while it is complex, I don't want to make it sound hopeless because there are actually prevention strategies that are proving effective. It's not that any one instance of suicide is necessarily preventable, it's that if you look at suicide from a public health standpoint, we certainly are just at the beginning as a nation of making that investment from a public health standpoint in the research programs and interventions that can reduce suicide, just like other leading causes of death have seen reductions in mortality when those investments have been made.

LuAnn Heinen:
Let's talk about suicide rates in the U.S. and who's most vulnerable.

Christine Yu Moutier, M.D.:
The latest data we have on suicide rates are from 2020, and that is, of course, during the period when the pandemic's onset occurred and goes through the early first nine months or so of the pandemic. What we know is that suicide had been a top 10 leading cause of death and that the national rate of suicide had been on the rise from 1999 through 2018 for a total of 35% increase in that national rate, which is a steady increase over two decades. Then from 2019 and then 2020, we saw the first declines actually, so that in 2020 suicide was the 12th leading cause of death, that was in part because COVID suddenly came on the scene and became the third leading cause of death. In terms of who is most vulnerable, it actually is the middle-aged group of adults from age 35 to 64, who showed the highest rates of suicide. There are some special kind of caveats there that amongst American Indian and Alaska native youth actually have the highest rates, but they comprise a smaller portion of the population, obviously. We still do think about the burden of suicide in terms of that middle-aged group. There are a couple other populations that are worth mentioning such as black youth and Hispanic Latinx youth, where their suicide rates are actually going in the wrong direction. It's a complex set of epidemiology, but the main point is that suicide, while it has a low-base rate in the overall population, it is generally considered preventable from a public health standpoint. We can make more investments. We can reduce risk for suicide and make strides and really need to target our attention in a public health manner so that there's a universal strategy that applies to everyone and then there are more targeted strategies for those populations who are identified to have higher risk. Then additional screening and care steps that are, of course, evidence based to really hone in on over time who is becoming at risk at any given moment in time.

LuAnn Heinen:
What about LGBTQ youth? Is there anything you could say about that group?

Christine Yu Moutier, M.D.:
Yes, LGBTQ youth are absolutely known to have a higher risk of suicidal behavior. We don't as a nation capture sexual orientation, gender identity, at the time of death, so it is a very problematic gap in the scientific data set, but we certainly know that suicide risk is likely to be much elevated amongst LGB, but also trans, in particular, trans youth and adults.

LuAnn Heinen:
What are the specific industries most at risk for suicide?

Christine Yu Moutier, M.D.:
We know from CDC national suicide mortality data, that some occupations do have higher rates of suicide than others. The industries that show those higher rates include the agricultural industry, fishing and farming, construction industry, law enforcement. Of course, we've seen rises in military rates of suicide, but also health care workers, including physicians and nurses. Those are some of the occupations that are known to have higher rates of suicide. When you think about what we had discussed about risk factors, those tend to be occupations where there is a culture of self-sufficiency, where self-sufficiency and stoicism are celebrated perhaps to the detriment of the recognition that all of those individuals, as strong and bright and high-

achieving as they are across all of those occupations, are also human beings and human beings all have physical and mental health. Sometimes suicide risk is part of something that is inherited through the genes and through early childhood experiences, let alone current stressful things that people face. The one thing to realize that is that it's not just about the environment of those industries that creates that higher risk of suicide. It's always going to be that interaction of risk factors.

LuAnn Heinen:
Thank you. You've alluded to the evidence base for suicide prevention. How robust is it and what are the barriers to implementing this in a public health model?

Christine Yu Moutier, M.D.:
The science is culminating in to what I would say, now we finally have consensus on several effective suicide prevention strategies. The CDC outlines those in their technical package on suicide prevention for communities and the Joint Commission and other accrediting agencies outline those in their guidelines for health systems. Like any good public health strategy, hopefully, the science will show both community-level as well as clinical treatment interventions that are effective at reducing suicide risk. So, yes, we have some of those now, and I would say, if you look at this from a sort of zoom out and the 30,000-foot view from a historical standpoint, we are just at the early phases of finding those effective strategies, so we can really still count possibly on maybe one or two hands the number of those interventions and programs that have that level of evidence, that reducing suicide risk.

LuAnn Heinen:
I'm talking with Dr. Christine Yu Moutier, a psychiatrist and expert on suicide prevention. She believes we need a public health approach to suicide prevention, one that recognizes risk factors and manages them over a lifetime, just as we do with other chronic conditions. We'll be back in a moment.

LuAnn Heinen:
We talked a little bit about risk factors. What are some of the protective factors and are these things that are well documented and well known to clinical community and also employer community?

Christine Yu Moutier, M.D.:
The protective factors for suicide are so important and the scientific literature really shows a few things. It shows that when people are perceiving a strong sense of social connection and support, that that is a protective factor and that's on an individual level, it's also on a population level. Other protective factors are access to health care, including mental health care. Especially when the sense of therapeutic alliance is strong between the person and their health care provider, that that seems to really rise up as a very prominent, protective factor. Other protective factors can be quite unique, actually, from the standpoint of what we call reasons for living. There actually is an inventory, a tool used in clinical settings called Reasons for Living that tap into an individual's sense of their own protective factors. That can be anything from their sense that their children, their pets, their job, their meaning and purpose in life. People who live with, for example, chronic suicidal thoughts, oftentimes in therapy are encouraged to develop that clear set of reasons for living, and will

even do some creative strategies around creating an actual sort of toolbox of coping strategies. This is even kind of an interesting one, but for gun owners, they might have those reasons for living that they write out and put it near where they store their gun, so that they're reminded of those connections to reasons to stay alive.

LuAnn Heinen:
Great example. I'm thinking about what employers can do themselves and through their partners. There's a major, major emphasis right now on mental health. It's a top priority for supporting employee well-being and for creating a positive culture for the new future workforce, really. We know that it's necessary for all the things that you're talking about as far as belonging and social connection and all the advantages that a workplace offers in terms of a structured work environment and often meaning and purpose and so on. Is it sufficient? What more could we do in the workplace?

Christine Yu Moutier, M.D.:
Well, one thing that I didn't mention about protective factors, but that I should mention, because it could absolutely be applied to workplace, is that the cultures, meaning a population of people around the world that have been studied, when the culture views help seeking without as much stigma or even as a sign of strength. Help seeking could be disclosing what you're going through to appear, help seeking could obviously also be seeking mental health, professional treatment or going to a primary care doctor. That attitude, that culture, around help seeking, and authenticity being a sign of strength, that is associated with reduced suicide rates in those populations. So, conversely, we know that certain occupations have a strong culture around stoicism and self-sufficiency and not disclosing what might be perceived as weakness in terms of human struggles and mental health struggles. Those happen to be some of the occupations with the very highest suicide rates.

I think the way that applies to a workplace is it can, of course the obvious things like making sure that mental health benefits are robust and EAP services included, and that those are being messaged in a way that makes them truly available because employees have to know about them in order to access them, but the less formal ways of addressing stigma in a workplace culture might be that the leadership, that supervisors, that different employee engagement groups, could take on some different messaging and campaign and education-type activities that could really specifically address stigma and essentially those efforts would show that this is a workplace where we don't have stigma about these kinds of real human concerns that happen to be in the mental health arena or the suicide related arena, and that these are things we can talk about. There's nothing more powerful than people talking about it and telling their stories in whatever workplace vehicle affords that, sometimes that could be through informal or formal mechanisms.

LuAnn Heinen:
There has been increasing interest in use of training programs in developing allyship among peers and training programs for supervisors. My perception, and what we're hearing is that this is beginning to have an impact on stigma around mental health conditions, generally anxiety and depression, talking about how you're feeling, are you okay? But whether it's gotten to the level that it's okay to talk about suicidal thoughts, I'm not sure that's happening.

Christine Yu Moutier, M.D.:
From a suicide prevention standpoint, anything that facilitates people who are struggling in any way, whether it's depression, anxiety, trauma, substance use, isolation, grief, anything that facilitates them getting connected with effective peer support and health care, has the potential to reduce suicide risk. In fact, some of the most effective suicide risk reducing strategies have been to actually very robustly identify and treat depression. That's more a health care setting model. Although it's been done on a population level, it's been shown in a number of places around the world. For example, in a particular region of Hungary that has some of the very highest suicide rates, not only for Hungary, which has high rates, but in the world, that a very aggressive program that trained primary care how to screen and treat depression when it's identified, actually reduce the suicide rate for that population while the program was going on. Then once it ran out of funding after two or three years, then the suicide rates came back up. With any suicide prevention strategy, it is

important that there is a sustained source of funding and a model that has a team that's actually taking inventory of what are the needs of the population over time, because those might change a little bit over time.

So, to your point about these training programs that are more mental health focused in the workplace, I think they are very valuable and will culminate in true suicide prevention efforts when they are sustained, when they are not in conflict with the informal culture in that particular workplace, and again, that's where all those other kind of messaging and creative efforts can augment more formal training. Then the last thing is that there is actually more specific suicide prevention education that can truly augment those mental health education programs as well. I would say that would be kind of like the last step, because it is also considered that mental health concerns, including depression, mood disorders in general, but anxiety as well, that those are some of the sort of top drivers of suicide risk. They are not the only ones and they don't occur in a vacuum either. Again, because suicide is multifaceted. It's almost always that there's a deterioration in mental health alongside several other risk factors. Those can be stressors that are going on in the person's life like financial stress, divorce. It can be even problems with performance. Remember humiliation and a feeling of stress, anxiety, and rejection, which is sometimes how work employees can perceive issues with performance, if other risk factors are present could be a very vulnerable time for employees.

LuAnn Heinen:
I was going to go there even before you mentioned financial concerns. One thing that employers are doing is focusing a lot on financial well-being and trying to address identifying and supporting people who need help with that, with serious financial concerns. Also supporting caregivers. During the pandemic, CDC said that caregivers who are caring for adults, their spouses, or their parents, who were also parenting young children, among that population 50% reported experiencing serious suicidal thoughts, the CDC said creating a desperate need for public health efforts tailored to them.

Christine Yu Moutier, M.D.:
Yes, I saw that as well. That issue of, I guess they call it unpaid caregivers, experiencing the very highest levels of distress during that early part of the pandemic, that's when I saw it come out of the CDC Household Pulse Survey, and I am very struck by that, and oftentimes they are workers in a workplace as well. I agree with you. I think it's a really important and kind of creative strategy for workplace leaders to be thinking about their employee base, not just from an occupational standpoint, but all the roles that they are playing and sort of, demographically the way that we know that the pandemic also had disproportionate effects on different types of populations. That is, I think, something very creative that would make a difference for the employee base and would also, I would think show, me as an employee, that my workplace is really pivoting in the moment to think about creative ways to meet our needs. I would think that that would make a big difference.

LuAnn Heinen:
Yes, and then the final area is around diversity, equity and inclusion, which is also in many Fortune 500 companies have been hiring, and especially in the last couple years an uptick in hiring chief diversity and inclusion officers, and that trickling down through the organization as a major priority should be helping on the inclusion front and social connection front.

Christine Yu Moutier, M.D.:
Yes, agreed. Even in the mental health and suicide prevention arena, we ourselves have been learning so much about how experiences of discrimination and even microaggression level racism, really any marginalized identity, being made to feel different or unworthy or not having the same access to resources and care and education and financial benefits and so forth. That has been kind of a revelation for me personally, when I learned about the study that found that among black adolescents tracking them over a period of weeks, that on average, they're experiencing around 5 experiences of discrimination per day, and those links to the impact on mental health and potential suicide risk. Again, the complicating thing for suicide is that it's not going to be monolithic. It's not going to be one experience or one type of experience. It's going to be that on top of, again, remember that in any employee base, you have lots of different levels of risk and types of risk factors that are just embedded in any general population, and probably some occupations have different clustering of risk

factors just based on who becomes attracted to certain types of jobs or a certain industry. But when you have that, it's always going to be that layering effect. Let me just pick on physicians and health workers, because that was how I started my own interest in suicide prevention. That if you have a population of people who is already driven to be inclined to pursue a health care profession, especially for physicians and nurses and some other health professions, that's going to mean a certain level of interest in serving others, probably deferring their own needs and perhaps not having to really experience or face their own mental health struggles in a way that teaches us how to view our own needs and our own well-being as a professional responsibility. I know that's a very different angle and I don't play that tune very often because we never want to blame the person who's going through a struggle. But when I'm talking to, let's say, a health care leadership about what they can be doing to prevent suicide and address the well-being of their health care workforce, I am going to be talking about it as a two-pronged approach, where there's individual things that we all can be doing to really treat our own mental health and well-being as a resource to ourselves and be really encouraging our colleagues, but then there's also an institutional and leadership responsibility to create an environment where that really can be done in a wholehearted way. It's that meeting of the top down and bottom up experience that can really create, I would call, like the best, most optimal safety net for preventing suicide.

LuAnn Heinen:
The COVID physician in New York was so sad.

Christine Yu Moutier, M.D.:
Yes, after Dr. Lorna Breen died by suicide, it has been really, truly like a lightning rod moment where suicide prevention already had become a priority for health care leaders and for medical education at the national level, the National Academy of Medicine included, has made well-being and mental health and suicide prevention a priority, and that was before COVID hit. When Dr. Breen died, I think that the unique aspects of her own life and story, for suicide prevention to really take root more deeply in any institution or in a population in the culture, it's oftentimes an experience of head knowledge syncing up with a heartfelt, heart wrenching experience, that kind of motivates action in a whole new and sustained strategic way. We really saw that happen after, unfortunately, Dr. Breen's tragic death has served in that way.

LuAnn Heinen:
Let's talk about how we communicate about suicide. You've used the term frozen to describe the way that colleagues, peers, friends, family members get when they're worried about someone.

Christine Yu Moutier, M.D.:
Oh yeah. Suicide is complex. It's been shrouded by myths and misinformation for millennia, and mental health even has had its own major amount of stigma that's just now showing major reductions, which is wonderful. But if you notice that a colleague is struggling or doesn't have to be in the workplace, it could be in your family, your neighborhood, your place of worship, we oftentimes aren't sure if we're right, number one. We second guess are those signs of behavior change that I'm noticing real and how to interpret them. We worry about offending the person or not being expert enough to have the conversation, to approach them. I think we've unconsciously, and to no one's fault really, made excuses to not approach real signs of distress and potentially signs of suicide risk because we haven't known what to do and we haven't wanted to offend the person. It really is a time now where I think people are doing it and are finding ways to, what I call, just have a coffee chat invitation, because it should be a one-on-one conversation where you can open up that dialogue. Really what it is, it’s just an invitation for the person to speak freely and to share with you as a trusted friend, family member, or colleague, about what's going on and knowing that this doesn't make you responsible for it, it allows you to maximize your role and responsibility as a friend, a loved one, or a colleague. That's all it is. We can certainly talk more about how to have that conversation, but I do see that there are signs of change. One thing at the American Foundation for Suicide Prevention that we co-developed with The Jed Foundation and the Ad Council was an ad campaign called, Seize the Awkward, because we heard from young people, this is an ad campaign for 16- to 24-year-olds, that they actually take their role as a friend so seriously and they know when their peers are struggling, but they didn't have the tools or the confidence to know how to approach the person. So, Seize the Awkward is a whole campaign that provides little tools and phrases and tips for how to

approach a peer that you're worried about. Again, it's a little funky because it was designed for and with young people.

LuAnn Heinen:
No, I like it, Seize the Awkward. Let's talk a little bit about the just launched in July, 988 hotline.

Christine Yu Moutier, M.D.:
988 is this incredible new phase of an opportunity to really re-envision, and certainly it is a rebrand of our National Suicide Prevention Lifeline, which has been in existence since 2005, woefully underfunded and under resourced for all of these years until this year. Congress passed the 988 legislation in 2020, which has allowed us to fund and prepare for this rollout that has just occurred in July. Just like there's 911 for physical health emergencies, we now have a three-digit number, 988, for mental health emergencies. It can be for any level of mental health distress, anxiety, depression, substance use problems or suicidal crisis.

LuAnn Heinen:
That's great. As I understand it, even though it was a federal push and grant money through, I think, the Substance Abuse and Mental Health Administration got it going, there's state responsibility. States need to pick it up and they're doing it in various ways I understand Mississippi, shout out to Mississippi, has the highest rate of answered calls or quickly answered calls, but that there's variability across the states.

Christine Yu Moutier, M.D.:
Yes, it is a national network made up of a central coordination by a group called Vibrant Emotional Health, that did receive the contract for 988 and has also been administering the National Suicide Prevention Lifeline all these years. But it's not just them. There are over 200 local crisis centers across all 50 states where the calls are routed to when somebody calls 988, and what that allows for is a level of local knowledge about the mental health resources, so that if follow up is warranted, it will be customized, you know, at that local level, that's really the ideal. And the other thing that is really incumbent upon states now to pass legislation on is the increased funding that's necessary to not just run these hotlines, but to build the mental health resources that will be multi-layered so that it's not just outpatient care, left to us to find it, or an emergency department or in-patient hospitalization or an emergency call, but that there would be layers such as mobile crisis teams, peer support, respite centers that are community based more so than in hospitals, so that there are, some communities have these, where there are four or five layers so that it can be customized to what is actually going on with the person and the specific mental health needs and the level of crisis that is going on. Intensive outpatient care, for example, rather than just outpatient or inpatient, there can be different levels of care.

LuAnn Heinen:
What else gives you hope?

Christine Yu Moutier, M.D.:
Well, the changes that I see happening, that includes in workplaces, but also includes in health systems in terms of patient care policies and procedures, it is a whole new day, because as I mentioned, that science and body of scientific knowledge is growing rapidly and really showing that there are things that, they have the evidence, they have the promise to reduce suicide risk, but if they're sitting on a shelf not being implemented, that is not going to reach people in need. What is exciting to me is that we see more really top-notch workplaces that are not only hearing the mental health needs of their workforce, but they understand that it will contribute to everything about their workplace - the culture, the reputation, the bottom line - all of those things can be kind of enhanced. Suicide prevention fits in that category very, very much. I think that level of scale that is being reached, as evidenced by the fact that at AFSP, we had to grow a whole new department to meet that demand, to partner with workplaces in their efforts to prevent suicide. That's been incredibly exciting and very gratifying. I think it is just the beginning, because this is hard work to do. It's not a one and done, you start wherever the workplace is ready, and then you work together to find the next steps that can deepen that work to really not only change the culture and enhance accessibility to mental health care, but all the other host of things in terms of education, peer support, and just that ongoing culture change.

LuAnn Heinen:
Christine, what's the most important thing employers and their partners should know about suicide prevention?

Christine Yu Moutier, M.D.:
I think the most important thing to know is that even though it has been a perhaps tricky or complicated topic, that like any issue of concern where science is showing results and answers, there are solutions that can be implemented. Any problem is going to have its complexities, but there are solutions that can be implemented. I think that is the main thing that I'd like them to be encouraged, that they can do this, this isn't undoable work, it is feasible. An example that I can give of just, again, of what gives me hope, but also of how tackling the issue of suicide prevention can be done, it's happened recently with the American Academy of Pediatrics. Now this is more of a clinical lens, but the fact is that for millennia, pediatricians were not trained in mental health or suicide prevention, but because the evidence became clear that there are steps that can really only be implemented in primary care, in a pediatric setting, the American Academy of Pediatrics took that on and AFSP co-developed a blueprint, a national blueprint for youth suicide prevention, where there are tangible steps and solutions. That same approach can be utilized for a workplace.

LuAnn Heinen:
For companies who are looking for more information about suicide prevention and specifically targeted to their workplace environment, what would you suggest?

Christine Yu Moutier, M.D.:
Well, just know that there are resources and programs. You don't have to go it alone on this either. There are groups like us at the American Foundation for Suicide Prevention who stand ready to help workplaces make this effort. But one website that I really like is https://workplacesuicideprevention.com/, and there are a host of links and resources on that website. Certainly at the American Foundation for Suicide Prevention, you can find programs and resources as well at https://afsp.org/.

LuAnn Heinen:
I've been speaking with Dr. Christine Yu Moutier, chief medical officer of the American Foundation for Suicide Prevention. She co-anchored CNN's Emmy award-winning, *Finding Hope*, a suicide prevention town hall, and authored the *Suicide Prevention* handbook for health professionals. You can follow her on twitter @cmoutierMD and learn more about the American Foundation for Suicide Prevention at https://afsp.org, including activities across the country, like Out of the Darkness Community Walks.

I'm LuAnn Heinen. This podcast is produced by Business Group on Health, with Connected Social Media. If you enjoyed this conversation, please rate us and share with a friend.