HRSA
Health Resources & Services Administration

Welcome to Behavioral Health Technical Assistance (BH TA) Virtual Peer Learning Office Hours

Supported by the HRSA Bureau of Primary Health Care (BPHC), Office of Quality Improvement (OQI)

Vision: Healthy Communities, Healthy People

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Depression and Suicidality Among Men

Joseph Hyde, MA, LMHC, CAS

Amber Murray, BSN, MA – Virtual TA/Office Hours Moderator

July 15, 2022
1:00 – 2:30 PM ET

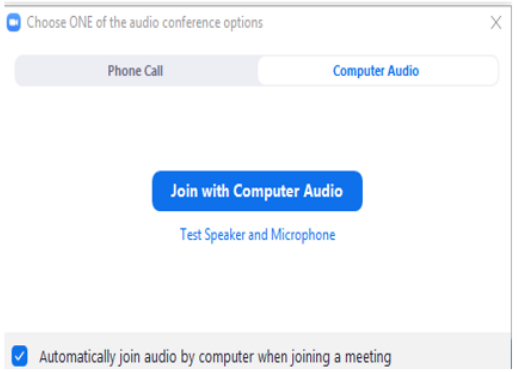
Vision: Healthy Communities, Healthy People

Housekeeping

To establish an audio connection:

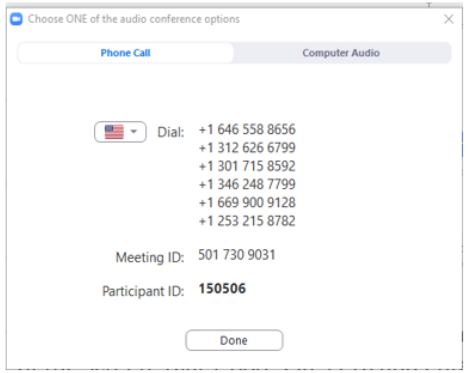
By computer:

- Click **Join with Computer Audio**.

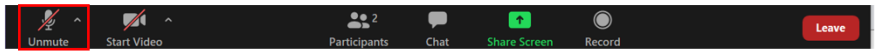


By phone:

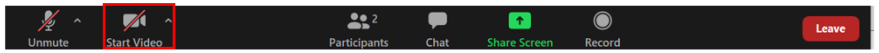
- Click the **Phone Call** tab, dial a listed phone number, and enter **Meeting ID** and **Participant ID**.



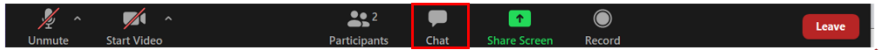
- You will begin muted. To **unmute/mute**, click the **microphone** icon located at the bottom left of your Zoom window.



- We encourage everyone to keep their video enabled. Click **Start Video** to join by webcam.



- To ask a question using the **Chat** feature, click the **Chat** icon located at the bottom center of your Zoom window.



Notes:

- **Please participate and, if possible, be on camera.**
- **Please mute your phone line if dialed in for audio and remain on mute until you would like to speak.**
- **This TA event is being recorded.**

Continuing Education

- We will be offering **1.5 CE credit** for your attendance at today's event.
- You **must** complete the Health Center Satisfaction Assessment to be eligible for CEs.
- **CE credits will be distributed within 3 weeks of the event.**

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Virtual TA: Presenters & Facilitators

Presenter:
Joe Hyde, LMHC, CAS
BHTA Project Director &
Technical Expert Lead
JBS International, Inc.

Facilitator:
Amber Murray, BSN, MA
Technical Expert & Task Lead
JBS International, Inc.

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About Today's Conversation

Breakout Discussion

Your Questions:

What are the main reasons you showed up for today's event? Why is this content important for you?

Today's Agenda

- Welcome & Introductions
- Presenter Presentation
  - **Depression and Suicidality Among Men**
- Facilitated Discussion
- Announcements
  - Office hours for this event
  - Future TA events
  - Satisfaction assessment

Source: iStock

Objectives for today discussion

1. Understanding Suicidality
2. Managing Suicidality
   - *Gathering Information Regarding Risk*
   - *Stratifying Risk*
   - *Planning and Responding*
   - *Documenting and Communicating*
3. Treating Suicidality
   - *Evidence Based Practices*

Source: iStock

A Key Point to Remember Before We Begin

Source: iStock

A patient's ambivalent thoughts about dying is an opportunity for you to save a life.

What is Suicide?

As defined by the CDC: “Suicide is death caused by injuring oneself with the intent to die. A suicide attempt is when someone harms themselves with any intent to end their life, but they do not die as a result of their actions.”[1]

- Suicide is not about wanting to die but rather about not wanting to live.
- Suicide is viewed as escaping unbearable suffering.
- Suicide is a means to end a situation in which a person feels trapped and experiences no hope.
- The most common emotion in suicide is hopelessness.
- ***No single explanation can account for all suicidal behavior.***
- Approximately, 50% of suicidal men also experience major depression.

1. Crosby A, Ortega L, Melanson C. Self-directed violence surveillance: Uniform definitions and recommended data elements, version 1.0 pdf icon[PDF – 1 MB]. (2011) Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 2. Thomas F. Oltmanns, Robert E. Emery, University of Virginia. Understanding Suicide, Common Elements

About Men and Suicide

- Evidence has been collected worldwide that indicates men are far less likely to seek help for mental health challenges, irrespective of age, nationality, ethnic or racial background. [1]
- Men are half as likely as women to seek services for depression and anxiety. [1]
- Normative masculine characteristics contributes to male reluctance to seek care. [2]
- Interestingly, men are more likely to seek care to address externalizing issues like alcohol misuse or anger management. [2]
- Mental health issues in men often remain hidden, overlooked or underdiagnosed. [2]
- **And 75% of suicide deaths are men.** [3]

1. Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. The Lancet. 2007;370(9590):841–50.
2. Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. American psychologist. 2003;58(1):5
3. Oliffe JL, Rossnagel E, Seidler ZE, Kealy D, Ogrodniczuk JS, Rice SM. Men's depression and suicide. Current psychiatry reports. 2019;21(10):103. pmid:3152226

Wisdom from Social Media on Suicide and Loss of Hope

Loss of Hope

- "A loss of hope is the lowest place to where our mind, heart and soul may travel. It goes beyond depression, suffering, pain, and leaves you at a place where even being sad has no purpose. It is a dangerous point to fall to, and anyone in that place for a long period will eventually succumb."
- "It is to believe that nothing will change, and I just don't see any point in anything."

Reddit

About Suicidal Ideation

- There are Two Types of Suicidal Ideation:
  - **Passive suicidal ideation** occurs when you wish you were dead or that you could die, but you don't actually have any plans to commit suicide.
  - **Active suicidal ideation** is not only thinking about it but having the intent to commit suicide, including planning how to do it.
- **Common to both:** These men are suffering.
- For many, the thought of suicide is comforting.

Redefining our Understanding of Suicide

- Suicide should be understood as a behavioral issue and treated as such [1]
- It is more than a manifestation of an underlying condition [2]

1. Hayes, S. C., & Hofmann, S. G. (Eds.). (2018). *Process-based CBT: The science and core clinical competencies of cognitive behavioral therapy*. New Harbinger Publications, Inc
2. Linehan, M. M. (1999). Standard protocol for assessing and treating suicidal behaviors for patients in treatment. In D. G. Jacobs (Ed.), *The Harvard Medical School guide to suicide assessment and intervention* (pp. 146–187). Jossey-Bass/Wiley.

Key Takeaways

Screening for depression, suicide and other behavioral health conditions should be a standard of care because:

If you don't ask, you don't know!

- When triage screening with the PHQ2, consider adding PHQ Q9 (self harm). Remember, not all suicidal patients are depressed.
- Screening can connect patients to a range of evidence-based behavioral health interventions that support health and well-being.

Questions So Far?

Question Mark Pile - Free image on Pixabay

Managing Suicidality

Risk Factors to Consider

Individual/ Personal	Social Level	Contextual/ Life Environment
• Hopelessness • Previous suicidal behavior • Gender (male) • Mental Illness • Chronic pain or illness • Immobility • Alcohol or other substance misuse • Low self-esteem • Low sense of control over life circumstances • Lack of meaning and purpose in life • Poor coping skills • Guilt and shame • Feeling like a burden to others	• Lack of social support • Abuse and violence • Social isolation • Family dispute, conflict and dysfunction • Separation/divorce • Bereavement • Significant Loss • Peer rejection • Imprisonment • Family history of suicide or mental illness	• Access to lethal means • Unemployment, economic insecurity • Financial stress • Neighborhood violence and crime • Poverty • School failure • Social or cultural discrimination • Homelessness • Exposure to environmental stressors • Geographical isolation

Common Misconceptions

- **Asking someone about suicide will increase the risk of suicide.**
  - It has been shown that asking someone about suicide lowers anxiety, opens up communication, and lowers the risk.
- **Only experts can stop a suicide.**
  - Anyone can stop a suicide: listen, show you care, provide hope.
- **Suicidal people don't talk about it.**
  - Most suicidal people give some sort of clue or communicate an intent prior to their attempt.

Common Misconceptions (Continued)

- **Those who talk about suicide don't do it.**
  - Those who talk about it may try and even complete a self-destructive act.
- **Once a person decides to attempt suicide, no one can change their mind.**
  - Suicide is a preventable form of death, almost any positive action may save a life.
- **No one can stop suicide.**
  - If people in crisis get the help they need, they are far less likely to attempt suicide.

Dos and Don'ts of Managing Suicidality

To Do

- Ask!
- Use your MI Skills: your kindness & compassion to engage
- Voice your concern
- Reinforce connection
- Offer reassurance (hope) that things can get better
- If they are at higher risk, do not leave them alone.
- Screen for severity of risk
- Make a plan
- Document
- **Always Follow up**

Not To Do

- Do not engage in philosophical discussions about suicide
- Do not describe it as attention seeking behavior
- Never promise to keep someone's suicidal feelings a secret
- Don’t try and talk patients out of thinking the way they are thinking
- Don't be patronizing or judgmental

Screening for Suicidal Risk

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** *Was this within the past three months?*	YES	NO

- Low Risk
- Moderate Risk
- High Risk

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Safety Planning with your Patient

1. **Knowing Warning signs.** Ask, “How will you know when this safety plan should be used?” and “what do you experience when you start to think about suicide?
2. **Using Coping strategies.** Ask, ”What can you do if/when thought and feelings begin to escalate?” Use MI skills and problem solving to help your patient self define coping strategies.
3. **Leverage Social Support.** Identify Family or friends who would offer help, ask, “who among your family or friends do you think you could contact for help during this difficult time? Who do you feel you can talk to when under stress?” Ask for several people and their contact information, ask “May I call them now with you to be sure they feel they can do this?”
4. **Identify Helpful Social Contacts**, Who May Distract From the Crisis, work with the client to help him/her understand that if step 2 or step 3 doesn’t work ask, “Who or what social setting help you take your mind off your problems? "Who helps you feel better when you are with them?”, Help them identify potential safe places they can go to be around people,(peer support center, coffee shop) Identify hotlines, and other resources . The goal is to distract the client from suicidal thoughts.
5. **Professionals and Agencies** during daytime and after hours, “Identify who should be on the safety plan?” List names contact information, in include MH crisis response and other supports such as the suicide lifeline. Provide increased support within the CHC.
6. **Making the Environment Safe**, Ask about lethal means availability, assure there is a plan to restrict access, include family and significant others to assure removal of means. Check with your local Law Enforcement contact to see if gun locks are provided. If at all possible, provide information to family about what to look for and what to do.

Evidence Based Risk Management

- Collaborative Assessment and Management of Suicidality (CAMS) (a proprietary model)
- CAMS is the most used suicide risk management model.
- This is provided as an informational resource only.

Documentation and Communication

- **The safety plan is in writing.**
  - Your patient has a copy and so do you. A copy of the plan should be entered into the EHR.
- Write a detailed progress note documenting your efforts.
- Document that you have followed agency P&P.
- Complete an incident report (if agency has one).
- Review what has happened and the plans with your supervisor.

Questions So Far?

Question Mark Pile - Free image on Pixabay

Treating Suicide: Evidence Based Approaches

There are evidence-based approaches for treatment.

- Dialectical Behavioral Therapy (DBT) Linehan, M. M. (1999). Standard protocol for assessing and treating suicidal behaviors for patients in treatment. (Proprietary)
- Cognitive Behavioral Therapy (CBT) Mewton, L., & Andrews, G. (2016). Cognitive behavioral therapy for suicidal behaviors: improving patient outcomes. *Psychology research and behavior management*, *9*, 21–29. https://doi.org/10.2147/PRBM.S84589 (Adults)
- Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., Kennard, B. D., Wagner, A., Cwik, M. F., Klomek, A. B., Goldstein, T., Vitiello, B., Barnett, S., Daniel, S., & Hughes, J. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *Journal of the American Academy of Child and Adolescent Psychiatry*, *48*(10), 1005–1013. https://doi.org/10.1097/CHI.0b013e3181b5dbfe (Youth)
- Medications Mourilhe, P., Stokes, P.E. Risks and Benefits of Selective Serotonin Reuptake Inhibitors in the Treatment of Depression. *Drug-Safety* **18,** 57–82 (2010). https://doi.org/10.2165/00002018-199818010-00005

Our Goals in Treatment

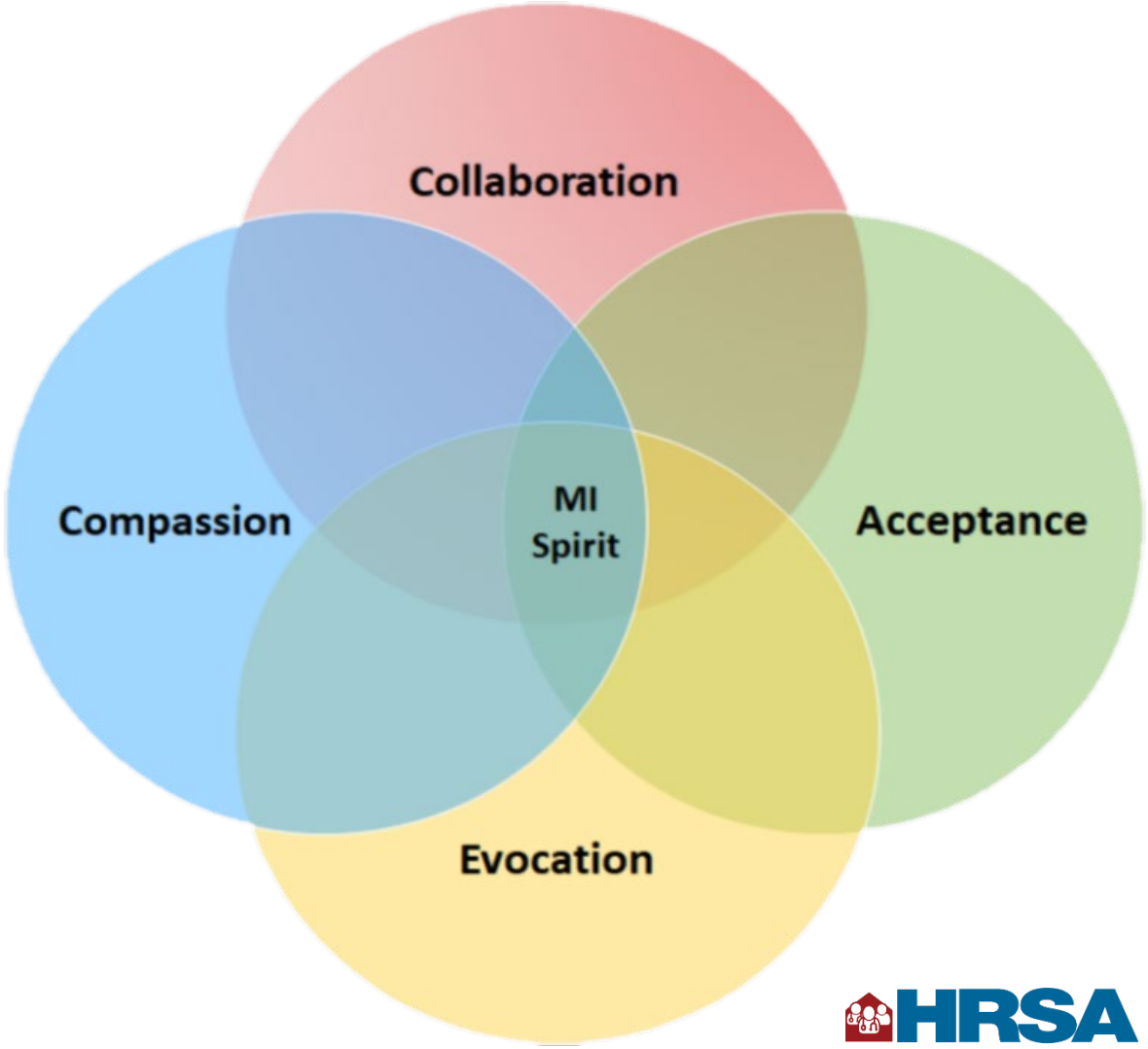
- Keep your Patient Alive
- Engage and Retain in Treatment
- Defuse Hopelessness
- Understand the Context and Variables in which your Patient's Suicidal Intent Lives
- Build and Implement a Treatment Plan that Addresses Hopelessness, Context and Variables

Hope, Connection and a Life Worth Living

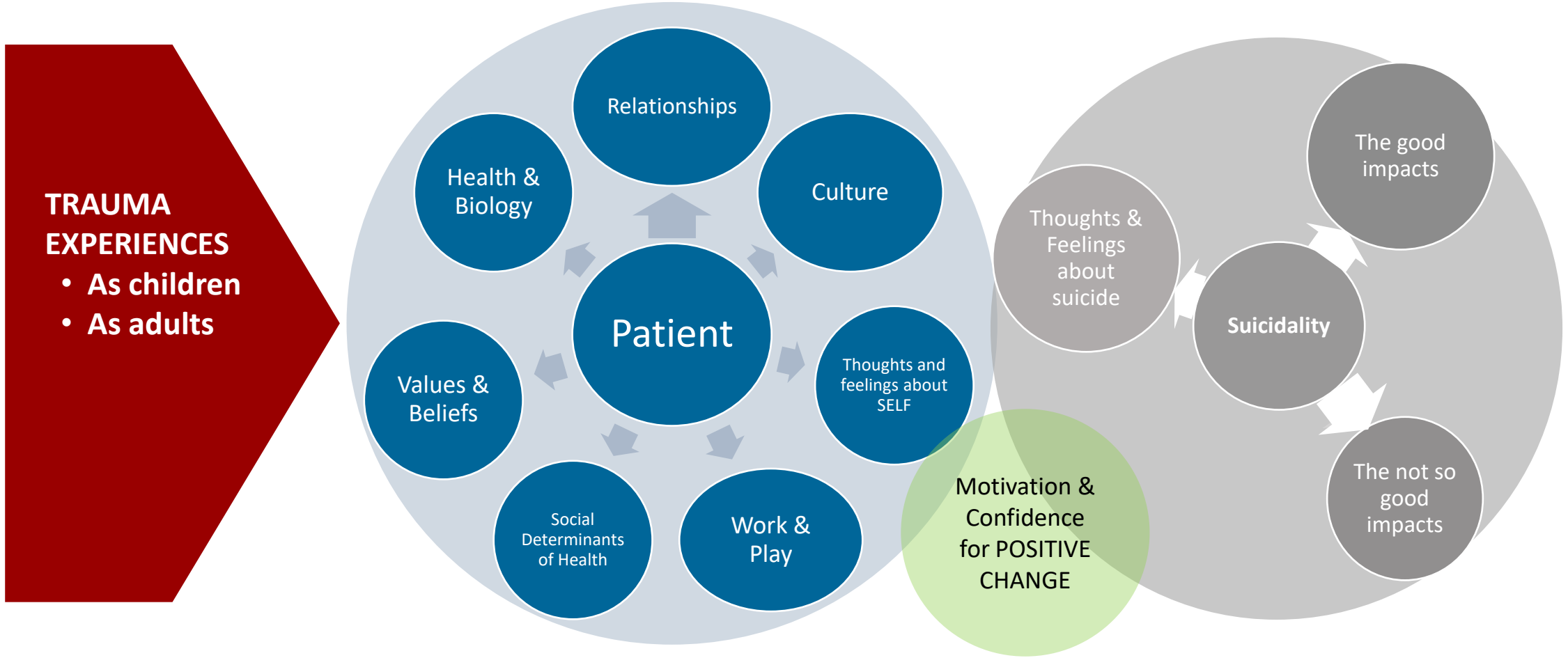
Despair and Darkness

Use of MI Now and Throughout Treatment

- Use your MI Spirit and Skills Supporting Engagement and Rapport Building
- Reinforce Hope and Hopefulness
- Support Defusion



A Contextual Understanding of Treating Suicidality



Suicide should be understood as a behavioral issue and treated as such.

What behavioral science and experience tell us: When we change a behavior like suicidality, this involves one or more changes in context.[3]

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[3] Hayes, S. C., & Hoffmann, S. G. (Eds.) (2018). *Process-based CBT: The science and core clinical competencies of cognitive behavioral therapy*. New Harbinger Publications.

Functional Analysis to Build Contextual Understanding

- Functional Analysis is important to better understand what are triggers, what are the drivers, what is relevant context

Awareness Record

As a way to increase awareness about your patterns of behavior, to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your behavior.
Describe Incident:

Trigger	Thoughts. Feelings and Beliefs	Intensity of feeling or desire	Behavior	Positive Results	Negative Results
		Low–high, 1–10	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Build a Plan That Deploys Behavioral Strategies Intervening with the Suicidal Variables

- Problem Solving
- Enhancing Social Support
- Reinforcing core values
- Mindfulness
- Assertiveness Skills
- Distancing from Painful Feelings and Thoughts
- Grounding
  - Dropping Anchor
  - Coping Skills (thoughts and feelings)
- Other CBT Skills

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Questions So Far?

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Wrap-Up Polling Question

What from today's session do you want to learn more about?

1. Suicidality in Men
2. Managing Suicidal Patients in My Clinic
3. Treating Suicidal Patients

BPHC-BH TA Portal

https://bphc-ta.jbsinternational.com/

- Request TA
- Access Learning Management System (LMS) modules
- Learn more about BH TA options
  - One-on-One Coaching
  - E-learning Webinars
  - Strategies for Community Outreach
  - Virtual Site Visits to Improve Outcomes
  - Join a Community of Practice (CoP)

TA Opportunities for Health Centers

- One-on-One Coaching
- Communities of Practices (CoPs)
- Virtual Intensive T/TA
- SDoH Roundtables
- Office Hours
- Webinars

Upcoming TA Opportunities

Virtual Peer TA Office Hours

UDS Depression Measures: How to Measure Them & How to Meet Them

Monday, July 25, 2022, 2:00 – 3:00 PM ET

Presenter: ***Chantal Laperle, MA, CPHQ, PCMH CCE, CTL***
Senior Program Manager, Advocates for Human Potential

Registration link: https://us06web.zoom.us/meeting/register/tZUoc-ivqzkpGtN6sHiSgo4X71mUwNycYp9e

Addressing Stigma Toward Individuals with Substance Use Disorders

Thursday, August 25, 2022, 11:00 – 12:00 AM ET

Presenter: ***R. Lyle Cooper, Ph.D., LCSW***
Assistant Professor
Meharry Medical College, Department of Family & Community Medicine

Registration link: https://us06web.zoom.us/meeting/register/tZ0qcOmgqjMiG9WIFaezjaCfq3rs2CKE6Pxp

BHTA Satisfaction Assessment

- We'd love your feedback – please complete a satisfaction assessment.
  - https://survey.alchemer.com/s3/6624870/Health-Center-TA-Satisfaction-Assessment-Office-Hours-General
- Remember! – if you want to obtain CEUs for your time today, you must complete a satisfaction assessment.
- There are two ways navigate to the assessment:
  1. Follow the link provided in the chat here.
  2. You will be emailed a link from us via Alchemer, our survey platform.

CE Revisited

- We will be offering **1 CE credit** for attending today's training.
- **You MUST complete the Health Center Satisfaction Assessment after each session for which you plan on receiving CEs.**
- CE credits will be distributed to training participants who complete the Satisfaction Assessment within 3 weeks of training.

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Thank You!

Please submit questions to

Amber Murray: amurray@jbsinternational.com

Joe Hyde: jhyde@jbsinternational.com

Open Mic Discussion