Addressing Suicide Disparity in Rural Communities:

A How-To Seminar That Focuses on the Areas of Prevention, Intervention, and Survivorship

Parts 1 & 2

Debra Brownlee, PHD

February 23, 2022

SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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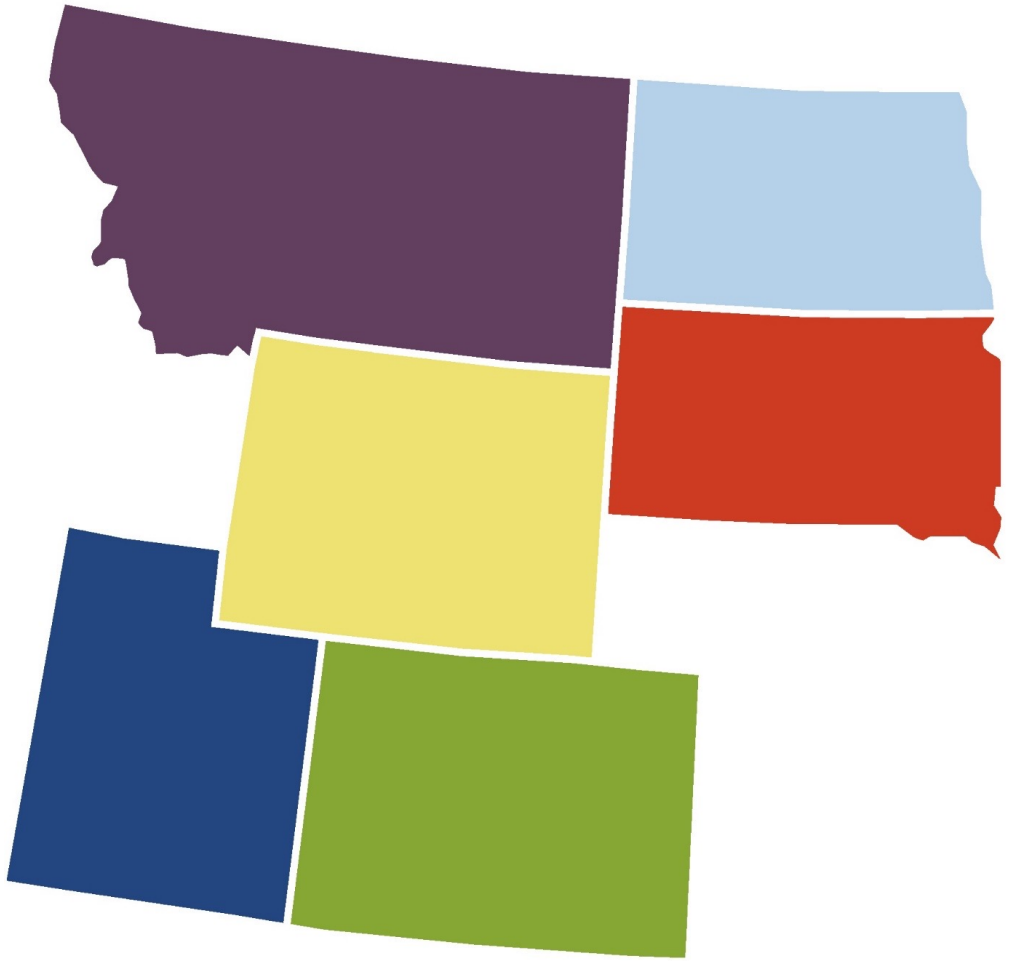
The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use, and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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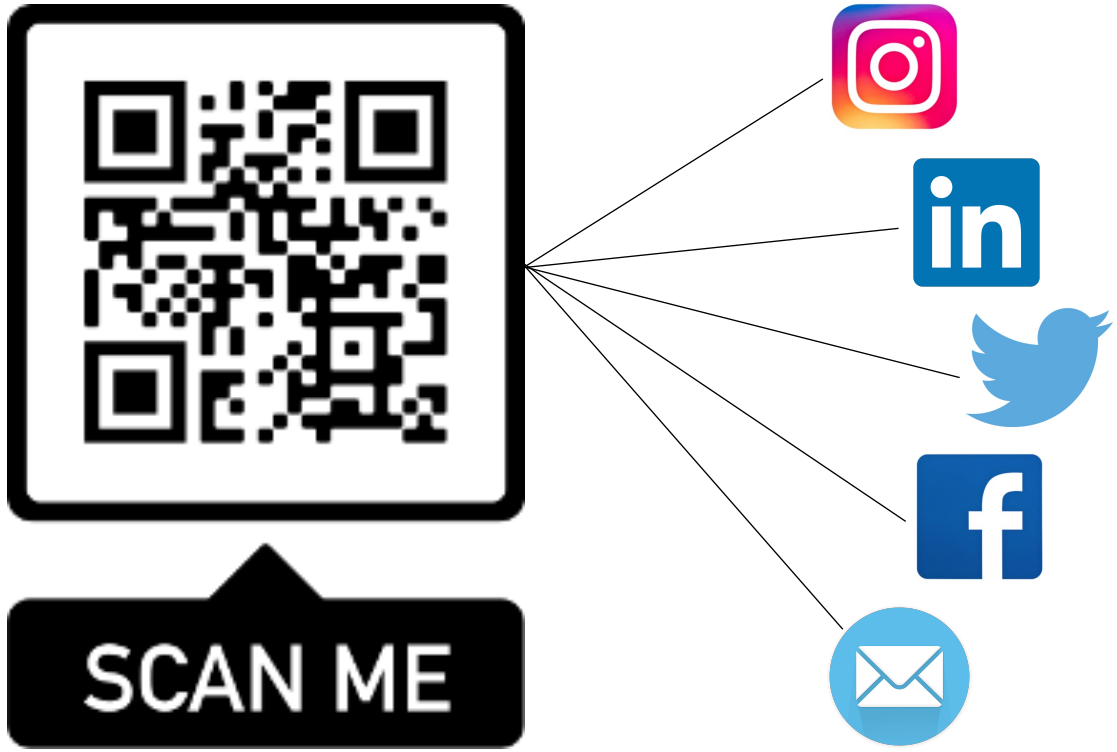

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ADDRESSING SUICIDE DISPARITY IN RURAL COMMUNITIES

A HOW-TO SEMINAR THAT FOCUSES ON THE AREAS OF PREVENTION, INTERVENTION, AND SURVIVORSHIP

TRAINER: DEBRA BROWNLEE, PHD

TRAINING OBJECTIVES

- 1. To increase understanding of the role that stigma plays in access of treatment for mental health services.
- 2. To provide an overview of the most common mental health concerns in the U.S.
- 3. To increase ability to identify signs, symptoms, risk factors, and protective factors of the most common mental health concerns.
- 4. To increase knowledge and comfort in ability to provide effective interventions in cases of crisis (e.g. suicidal ideation; panic attack; trauma flashback; and interactions with people experiencing active substance use and psychosis).
- To provide a forum for discussion of and suggestions for suicide survivorship within the family; community; and schools.
- 5. To increase knowledge of Compassion Satisfaction vs. Compassion Fatigue through use of the Professional Quality of Life Scale.

WHAT THIS TRAINING IS VS. IS NOT

- This training is intended to provide a basic and general understanding of mental health issues. It is not intended to teach participants how to diagnose/treat specific mental health conditions and will not cover specific medication/medical treatments. Ideas regarding further areas of training will be provided at the end of this training for those who are interested in gaining more specific and in-depth understanding of mental health diagnoses/treatment.

STIGMA

Activity: In one minute, how many terms can you identify for "mental health" (e.g. crazy, nuts, etc…)?

How easy did the words on your list come to you?

How often to you hear these words/terms come up in everyday conversation?

The language we use

Words Matter!!

- Imagine that person you're trying to help. Think of them sitting in the corner of the room listening to every word you use to describe them. Imagine them reading the treatment notes you've written about them.
  - How likely would it be that they would want to tell you about what they're experiencing given what they heard/read?
  - Do your words conform to a stereotype or stigma?
  - Many mental health conditions present with a restricted range of emotion (e.g. psychosis, trauma, substance use). Just because a person doesn't show emotion, it doesn't necessarily mean that they aren't understanding or feeling.
  - Mental Illness is not correlated with intelligence and it most definitely is not correlated with hearing.

STIGMA

Scenario 1

Your neighbor's spouse is hospitalized due to a heart attack. What is your response? How do you support your neighbor?

Scenario 2

Your neighbor's spouse is hospitalized due to depression and/or substance use problem. What is your response? How do you support your neighbor?

Any differences in response? If so, why?

When you hear the term "Physical Health" what do you think of?

When you hear the term "Mental Health" what do you think of?

STIGMA

Have you ever had a cold/flu?

Have you ever needed a cast or stitches?

All illness is a continuum

- Physical and Mental health symptoms are a part of human existence. Everyone alive has experienced sadness, fear, anxiety in some form.
- Most people experiencing physical/mental health symptoms don't require formal treatment. Symptoms often get better with time.
  - When treatment is needed, it's usually minimal and time-limited.
  - In more rare cases, symptoms are life-long requiring on-going treatment.

Have you ever been so anxious you couldn't sleep?

Have you ever grieved the loss of a loved-one?

STIGMA

Nobody does anything for 'no good reason'

- The Fundamental Attributional Error
- Perspective matters/it's the individual's experience that matters
- Every person has a right to address their personal concerns vs. the concerns of the treatment provider
- Everyone has strengths on which to build
- Providers act as helpers/guides rather than taking on the role of "fixer".

WHAT ARE THE ISSUES?

Remember: In every interaction, you bring your own skills and experience

The same strategy will most certainly not work with all people

- What are the most common struggles experienced by the people you work along side?
- What are the typical strategies you use (perhaps even without thinking of it as a strategy)?
- What has worked well? What has proven to not work well?

Strategies that work for someone else may not work for you

MENTAL HEALTH PROBLEMS (12 MONTH PREVALENCE)

Adults

- Anxiety Disorders (18.1%)
- Major Depressive Disorder (6.8%)
- Substance Use Disorder (8.1%)
- Bipolar Disorder (2.8%)
- Eating Disorders (5-10%)
- Schizophrenia (0.3-0.7%)

Youth (ages 13-18)

- Anxiety Disorders (31.9%) w/severe impact (8.3%)
- Behavior Disorders (19.1%) w/severe impact (9.6%)
- Mood Disorders (14.3%) w/severe impact (11.2%)
- Substance Use Disorders (11.4%)

STATISTICS WORTH MENTIONING

- afsp.org (American Foundation for Suicide Prevention)
- sprc.org (Suicide Prevention Resource Center)

STATISTICS WORTH MENTIONING

Only 41% of people with a mental illness use mental health services in any given year (Why might that be?)

Median Age of Onset

- Anxiety Disorders (Age ???)
- Eating Disorders (Age ???)
- Substance Use Disorders (Age ???)
- Schizophrenia (Age ???)
- Bipolar (Age ???)
- Depression (Age ???)

1/2 of all mental disorders begin by age 14 and 3/4 began by age 24 (based on 1st report of symptoms)

There is a significant delay in accessing mental health services. Can you guess the median time it takes for an individual to access treatment?

STATISTICS WORTH MENTIONING

Median Age of Onset

- Anxiety Disorders (Age 7)
- Eating Disorders (Age 12)
- Substance Use Disorders (Age 15)
- Schizophrenia (Age 22)
- Bipolar (Age 25)
- Depression (Age 32)

THE APPROACH

National Suicide Prevention Lifeline 1-800-273-TALK (8255)

- Communication is imperfect but mistakes in communication can usually be fixed.
- Be specific in describing what you are noticing and/or what your concerns are.
- Your best skills involve being genuine, compassionate, and respectful.
- The more ill someone is, the more clear you have to be (e.g. you may have to take more time explaining why you're asking the questions you are; what your intentions are, etc…)
- Take your time. Most decisions don't have to be made right away. (If they're talking, they're not acting)
- Remember, you are not the sole decision maker. You are able to access support through the National Suicide Prevention Lifeline, afsp.org (American Foundation for Suicide Prevention), sprc.org (Suicide Prevention Resource Center); and 911 is always an option if you aren't sure a person can keep themselves safe.
- Put the National Suicide Prevention Lifeline Number in your phone contacts list (1-800-273-8255).
- If you do call 911, tell the operator that this is a mental health crisis and ask if they can send someone trained to help with mental health issues.

Activity: Take a minute to consider helpful/not helpful things to say

THE APPROACH

Examples of What to Say

- I'm concerned about you.
- It looks like you're having a hard time concentrating, focusing, getting to appointments on time, etc…
- You seem to be more anxious, sad, angry, etc… than usual (then give specifics: e.g. you look like you've been crying; you've been snapping/yelling more than usual; you're trembling.
- Would it help to talk? I'm here when you're ready to talk.

Examples of What Not to Say

- Get over it.
- You're making a bigger deal of this than you need to.
- Calm down.
- You just need to…. What you should do is…
- Have you done what we talked about before (e.g. taken your meds, stopped drinking/drugs, etc…)

MOST COMMON CRISES

- Suicidal Ideation/Non-Suicidal Self Harm
- Panic Attacks
- Reactions to Traumatic Events (e.g. flashbacks)
- Substance Use
- Psychosis

SIGNS VS. SYMPTOMS

What's the Difference?

SIGNS & SYMPTOMS

Bonus Points if you can identify any that may be both signs & symptoms

What you see/witness

- Crying
- Sweating
- Shaking
- Rapid Speech
- Dark Circles Under Eyes
- Yelling
- What Else?

What they report

- Hopelessness
- Helplessness
- Low Self Worth
- Exhausted
- Loneliness
- Butterflies in Stomach
- Worried
- What Else?

SIGNS AND SYMPTOMS

- Suicidal Ideation/Non-Suicidal Self Harm
- Panic Attacks
- Reactions to Traumatic Events (e.g. flashbacks)
- Substance Use
- Psychosis

What are specific signs and symptoms of each?

RISK FACTORS

- Uncontrollable or Traumatic Events
- History of Childhood anxiety/stress
- Ongoing Stress/Anxiety
- Co-Occurring Disorders
- Prior history of mental illness
- Family History
- Medical Side Effects

- Medical Illness that is Life Threatening, chronic, or associated with pain
- Recent Childbirth
- Changes in Hormone Levels
- Lack of Exposure to Light in Winter
- Substance Misuse; Intoxication; or withdrawal
- What Else?

PROTECTIVE FACTORS

What might some protective factors be?

SUICIDE RISK ASSESSMENT

Factors to Consider

- Gender
- Age
- Chronic Physical Illness
- Mental Illness
- Alcohol or other Substance Use
- Social Support
- History of suicide attempts
- Organized Plan

Warning Signs

- Threats of harming or killing self
- Seeking Access to Means
- Talking/writing/posting about death/dying/suicide
- Feelings of hopelessness, low self-worth, lack of purpose
- Acting recklessly/High risk behaviors
- Feeling trapped, stuck, powerless
- Increased alcohol/drug use
- Withdrawing from others
- Rage/Anger/Seeking Revenge
- Increased agitation
- Dramatic Change in Mood

SUICIDE RISK ASSESSMENT

How to Approach

- Let them know that you're concerned and want to help
- Discuss your observations with them
- Ask the question without dread
- Avoid negative judgments
- Appear confident

Questions to Ask

- Are you having thoughts of suicide?
- Are you thinking about killing yourself?

If Yes:

- Have you thought about how you would do it?
- Have you decided when you would do it?
- Have you gathered the things you would need to carry out your plan?

KEEPING THEM SAFE

National Suicide Prevention Lifeline
1-800-273-TALK
(8255)

Do

- Provide a safety contact number
- Help them identify past supports
- Involve them in decision making
- Call law enforcement immediately if the person has a weapon or is behaving aggressively

Do Not

- Leave an actively suicidal person alone
- Use guilt or threats
- Agree to keep their plan a secret

TRUE – FALSE – SOMEWHERE IN-BETWEEN

SUICIDE SURVIVORSHIP

The person who dies by suicide dies a single death, while those left behind die a thousand deaths

- AFSP.org
- Alliance of Hope for Suicide Loss Survivors (allianceofhope.org)

PANIC ATTACKS & FLASHBACKS

- What does a panic attack look like?
- What does a flashback look like?

PANIC ATTACKS & FLASHBACKS

How to Approach

- Keep your distance
- Remain Calm
- Speak in a reassuring but firm manner
- Speak slowly/clearly
- Use short sentences
- Remind them that the symptoms are not life threatening
- Reassure them that they are safe and that panic symptoms typically last no more than 20 minutes
- Avoid expressing your own negative reactions

Questions to Ask/Things to Say

- Do you know what's happening? (Panic attacks can look like a heart attack. If they don't know, you're calling 911 immediately)
- Can you tell me what you need?
- Can I call anyone to help?
- What's helped in the past?
- Do you want to go to a quiet room? Do you need to pace?
- I'm going to stay with you until the symptoms go away (or until professional help arrives).

SUBSTANCE USE (WHEN IS IT A PROBLEM?)

- Increased use over time
- Increased tolerance
- Difficulties controlling use (using at inappropriate times or inappropriate locations, etc…)
- Symptoms of withdrawal
- Preoccupation
- Giving up important activities
- Continued use in spite of recognizing a problem

SUBSTANCE USE

How to Approach

- Nonjudgmental approach
- Realize their perception of the problem may be different than yours
- Blackouts are real. They may not have the same memory of events as you or others do
- Be open and honest about what your concerns are. Use specific examples from an "What I've noticed is" perspective
- Realize that they may not want to quit. Their goals may be different than you would want for them

Questions to Ask/Things to Say

- "Nobody does anything for no good reason. If a person is using a substance, whatever it is, it's serving a purpose. What does it do for you? How does it help?"
- "Do you think that your use of _____ is holding you back or leading to problems?"
- "Have you tried to cut back or quit?" "What was that like?"
- "What assistance do you think would help you?"

Any other ideas?

PSYCHOSIS

What does psychosis look like?

What are common misperceptions of psychosis?

Bonus Points: Do you remember the incidence rate?

PSYCHOSIS - SYMPTOMS

- Depression
- Anxiety
- Irritability
- Suspiciousness/Paranoia
- Blunted/Flat Affect or Inappropriate Emotions
- Delusions
- Hallucinations
- Disorganized Speech/Behavior
- Social Withdrawal
- Poor Concentration/Memory
- Mania

PSYCHOSIS

How to Approach

- Nonjudgmental approach
- Choose a location free from distractions
- State the specific behaviors that concern you
- Let them set the pace
- Keep your distance
- Do not force them to talk about their experiences/beliefs but listen respectfully if they choose to
- Remember that they are possibly experiencing their environment in a very different way than you are. Be respectful of that.

Questions to Ask/Things to Say

- "I notice that you keep looking over your shoulder. Are you seeing or hearing things that others don't?" (It really is ok to be this blunt).
- Can you tell me what you're seeing/hearing (e.g. how many voices? What are they saying? Are they telling you to do anything? Are they scary or comforting?)
- "Are you able to push the voices into the background while we talk?"
- Do not join in their delusions

Anything else that's worked for you?

BREAKOUT GROUPS

- Think about a person you have been concerned about during the course of your work. Prepare a short vignette that includes the major concerns and relevant factors regarding this individual. Please avoid too much identifying information (e.g. no names or information that isn't relevant to the symptomology). We will be breaking into small groups to discuss action and crisis planning/intervention. The hope is that this practice will lead to greater comfort in approaching/ addressing the problems as well as gathering support around ourselves as we work with others.

BREAKOUT GROUPS
VIGNETTES

1. How will you approach? What's your starting sentence? Where will you have this conversation? What do you need to be mindful of when approaching this person?
2. What are the particular Risk Factors involved?
3. What are the particular Protective Factors involved?
4. What resources will you utilize?
5. What supports will you gather around yourself?
6. What are some goals/strategies for future interactions with this individual?

PROFESSIONAL QUALITY OF LIFE MEASURE

ProQOL.org

In association with The Center for Victims of Torture

Thank You!

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Addressing Suicide Disparity in Rural Communities:

Part 2 – Compassion Fatigue
The Risks & Rewards of Being a Caregiver

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Compassion Fatigue

The Risks and Rewards of being a caregiver

ProQOL.org
In association with
The Center for
Victims of Torture

Compassion Satisfaction/Fati

Compassion Fatigue
This is the bad stuff

- “My work doesn’t matter”
- “I’m not supported at work”
- “I don’t have a say”
- “I’m overwhelmed”
- “I don’t get along with my co-workers”

Compassion Satisfaction:
This is the good stuff

- “I make a difference”
- “I’m good at what I do”
- “I like the people I work with”
- “I’m doing important work”
- “I’m doing the work I was meant to do”.

The 2 sides of Compassion Fatigue

Burnout (being worn-out)

- Feeling inefficient
- Feeling overwhelmed
- Feeling hopeless
- Comes on slo

Traumatic Stress (being afraid)

- Primary Traumatic Stress (actually involved in/witnessing the trauma)
- Secondary Traumatic Stress (hearing about or somehow related to traumatized people)

ProQol

- Professional Quality of Life Survey

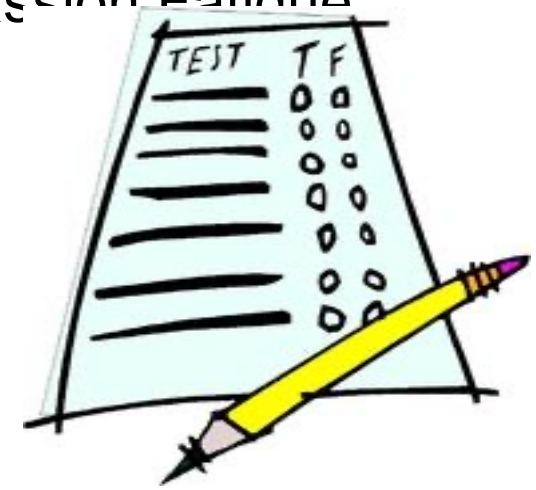
❖ Developed by Beth Hudnall-Stam of Idaho State University.

❖ 30 item questionnaire that helps understand the positive and negative aspects of helping

❖ Measures Compassion Satisfaction and Compassion Fatigue

❖ Compassion Fatigue has two subscales

- ✓ Secondary Trauma
- ✓ Burnout



***www.proquol.org* (for more information)**

People Bring themselves

- People bring a past and a present to anything they do.
- Some people bring with them histories that may include trauma
- A person's trauma history may color the way they think of and interact with people and situations.

- Each person has his/her own:

✓ Beliefs

✓ Stigmas

✓ Social Support Systems (positive and negative)

✓ History of trauma and illness

✓ Economic situation

Resiliency Planning

- Individual, personally

The Proqol can help you plan where to put your energy to increase resilience

- Organizational Planning

Can help organizations find ways to maximize the positive aspects and reduce the negative aspects of helping

- Supportive Supervision

The Proqol can be used as information for discussions

Caring for yourself in the face of difficult work (www.proquol.org for a wallet sized copy)

10 things to do for each day

1. Get enough sleep
2. Get enough to eat
3. Do some light exercise
4. Vary the work that you do
5. Do something pleasurable
6. Focus on what you do well
7. Learn from your mistakes
8. Share a private joke
9. Pray, meditate, or relax
10. Support a colleague

Switching On and Off

1. Switching is a conscious process. Talk to yourself as you switch
2. Use images that make you feel safe and protected (switch off) or connected and cared for (switch on) to help you switch
3. Find rituals that help you switch as you start and stop work
4. Breathe slowly and deeply to calm yourself when starting a tough job

Remember!

Your ability to care for others is related to your ability to care for yourself

Areas for Future Development

If you are interested in learning more specific techniques, I suggest the following:

1. Dialectical Behavioral Therapy (really good for work with populations in heightened emotional distress). Marsha Linehan from U.W.
2. Motivational Interviewing (typically known for use in facilitating change behaviors: e.g. addictions). William Miller & Stephen Rollnick.
3. Mindfulness Based Stress Reduction (there's a free training available through PalouseMindfulness.com). John Kabat-Zinn
4. Mental Health First Aid (there are versions for people who work with adults and people who work with youth. Mentalhealthfirstaid.org)
5. National Alliance on Mental Illness (nami.org) Good resources for people experiencing mental health problems as well as those who support people with mental health problems. I often provide this site to my clients.
6. Suicide Prevention Toolkit for Primary Care Practices (Native American Addendum) sprc.org

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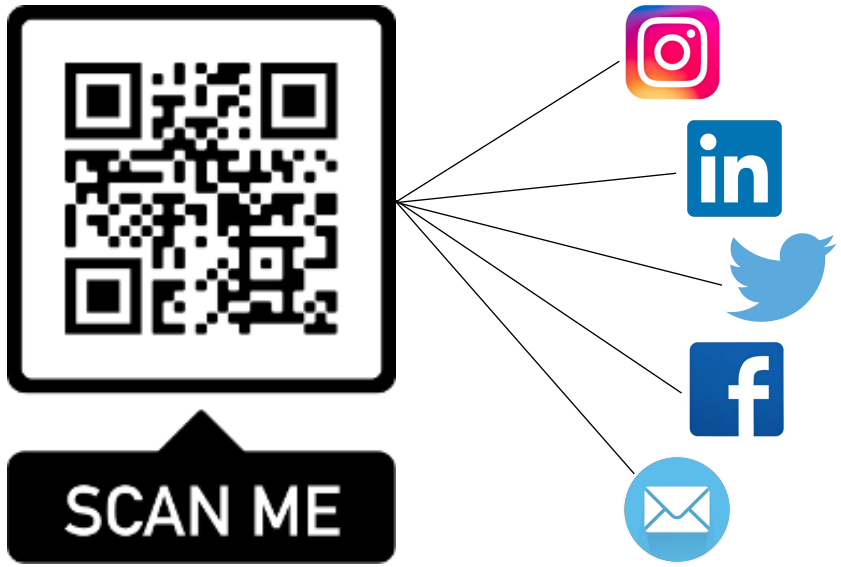

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