FIXING MENTAL HEALTH CARE

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Dear (name),
First off, let me wish all of you a Happy Holiday Season! I know this has been a trying year for many, especially because of national and international events. I'm reminded of Queen Elizabeth's annual address in 1992. Windsor Castle had suffered extensive fire damage and her family had undergone considerable personal turmoil. She referred to the year as her "annus horribilis." But she prospered after that, perhaps taking Winston Churchill's advice that, "When you're going through hell, keep going." I pray that you and I can follow that wisdom and make 2024 our "annus mirabilis," our wonderful year.

I have perhaps a bit of good news for you about mental health. We've all be led to believe that the holidays, especially Christmas, are times when suicides peak, ostensibly from memories past that do not match our present reality. Well, that's flat out wrong! Past reports vary but show rates to be 15% to 25% lower. 2021 data from the CDC (the last year with complete data) indicate that December, January, February, and April have the lowest suicide rates of all the months while the worst ones are August, September, and October). Nevertheless, rates remain in the 48,000 per year range over now many years.

U.S. Army: Suicide Prevention; PD US Army; CCO License

That's way too high, especially when we can prevent many of them. Just like we need to know CPR and the Heimlich maneuver to prevent unnecessary physical deaths, we can also prevent

suicides by following the steps I'll review from my *Psychiatry in Primary Care* textbook and a blog in Psychology Today,

First, it's important to recognize *high-risk situations* where suicide is more likely.

- Depression and other mental disorders, including substance abuse.
- Chronic physical disease, especially when disabling and associated with chronic pain.
- Prior suicide attempt or a family history of suicide, mental disorder, or substance abuse
- Past or present history of abuse, especially chronic
- Firearms in the home
- Recently released from prison or jail
- Exposure to suicides, including those of prominently celebrities as well as those close to the person.

Then, there are direct *clues in individuals that should make you suspicious* of suicidal risk.

- Talking about wanting to die or feeling hopeless with no reason to live.
- Talking more often about death
- Planning or exploring a way to kill themselves, perhaps looking online, stocking sleeping pills, or buying a gun.
- Obsessing about how guilty and ashamed they feel
- Complaining of feeling trapped with no escape or solution
- Experiencing unbearable emotional or physical pain
- Talking about being a burden to others
- Withdrawing from family and friends
- Acting anxious or agitated
- Using more alcohol and/or drugs
- Changes in eating and sleeping habits.
- Mood swings from very sad to very happy or even calm.
- Becoming rageful and speaking of revenge
- Taking unusual risks, such as speeding
- Giving away important possessions and/or putting affairs in order, such as drawing up a will
- Saying goodbye to friends and family.

Now, what do you do if you have concern about a friend or family member or colleague? To begin, be reassured that the adage that asking about suicide puts the thought into a person's mind is not correct. It's perfectly okay and safe to ask. Here's how.

You start by establishing a caring relationship, letting the person know you are interested in their wellbeing, perhaps having a 1–2-minute conversation about how things are going, listening for the above clues. It's perfectly appropriate to ask about their feelings or emotions, indeed, I recommend this, simply ask directly with something like, "What's the feeling that goes with that lost job (divorce; cancer diagnosis; death in the family; having no dates; flunking a test)?" It's important to hear this out for a minute or two until you have a pretty good understanding of the situation. Then you use the empathic skills to address the emotion you have discovered, for

example, that the person is upset or worried or angry or depressed. Unfortunately, while everyone tells us we should "be empathic," no one tells us how. I coined a mnemonic to help remember these empathic skills. We **NURS** the emotion by

- **N**aming it ("…so you're pretty angry [worried, depressed, upset, stressed] …")
- **U**nderstanding it ("…makes sense to me, I understand…")
- **R**especting it ("…thanks for telling me, you've had a tough time…")
- **S**upporting it ("…let me know how I can help…").

After understanding the problem and NURSing the patient's emotion a few times, it's time to directly inquire about suicidal intent.

You ask two questions.

1. Continuing in a supportive way, ask directly, for example, saying something like, "I'm concerned about you, that's a lot to go through. Some people might have ***thoughts of death*** with all you're dealing with, perhaps that life isn't worth living or hoping just not to wake up in the morning. Have you had these thoughts?" Having thoughts of death does not mean someone is suicidal, but it's serious business, adding further to the suspicion that prompted you to inquire. If there have been no thoughts about death, you need go no further, just continue being supportive around whatever problem occasioned the conversation. On the other hand, if they have these thoughts, you now determine if the distressed person is suicidal.
2. Inquire about specific ***thoughts of suicide or self-harm***, perhaps saying, "Sometimes people with those thoughts about death you mentioned think of taking their own life, have you ever thought about taking your life (or harming yourself)?" The answer (and how it's given) is critical. "No, I don't want to go to hell," one person might respond emphatically; another might say, "Absolutely not, who'd take care of my cat?" If you get a convincing negative answer, nothing further is needed except to be supportive around their problem. But, if you do not get a clear rejection of the idea of suicide, for example, the person hedging, or if they say they have thought about taking their life, you have a <u>four-alarm emergency</u>.

US Navy: Suicide Prevention; CC-PD-Mark;PD

Providing continued supportive comments, you now must ensure that they receive <u>immediate help</u>, the problem more serious if you learn they have a specific plan for killing or harming themselves (a collection of pills, a gun, tubing to connect to a car exhaust—remove them if possible). Don't just advise the person to get help, <u>take them</u> to their doctor or the nearest emergency room. If they refuse, call the police at 911. In any event, do not let them out of sight until under care. This is how these valuable lives can be saved.

I understand how difficult and scary this can be, but please try it, you can save a life.

Here's a tip to make this easier. Imagine a scenario in which a person has suicidal intent. Rehearse the statements above in your own mind or with someone else. It helps to first have this experience verbalizing what you'll say before you get into the stress of an actual interaction.

I'm excited to have heard back from so many of you—please keep me updated on what you're doing. It's good to reconnect.

As you know, I am trying to improve mental health care and other aspects of psychosocial medicine, so I'd appreciate any assist you can provide. There are three things in particular that would help spread the word:

1. Pass my website (Personal Website) along to your mailing list and others and recommend that they subscribe (lower right-hand corner of each page) to this Newsletter.
2. Like, comment, forward, or share on your social media any of these Newsletters that really resonate.
3. Follow me on social media (see below).

Also, I'd appreciate feedback on these Newsletters and requests for topics you'd like to hear about in the future.

Thanks for following and take care and have a Happy Holiday Season!

Bob

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