the Learning Centre

QC32: EARS Online

Working with suicidal people

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Zoom Keeping

- Mute when not speaking
- Use of on-line chat
- Mobile Phone to silent
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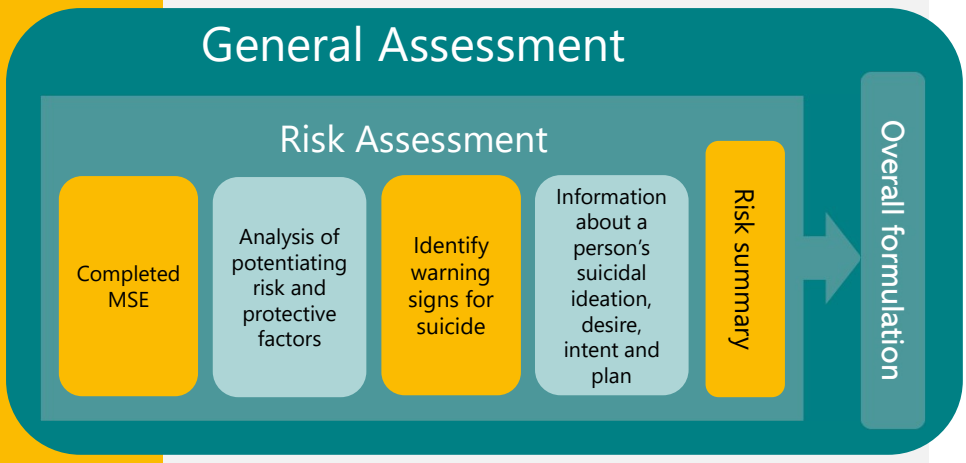
- Breaks
- Attendance
- CPD Points
- Group Agreement

6

What is our focus today?



7

Learning outcomes

Facts and Stats

Gain knowledge of the basic epidemiology of youth suicide

Values and Attitudes

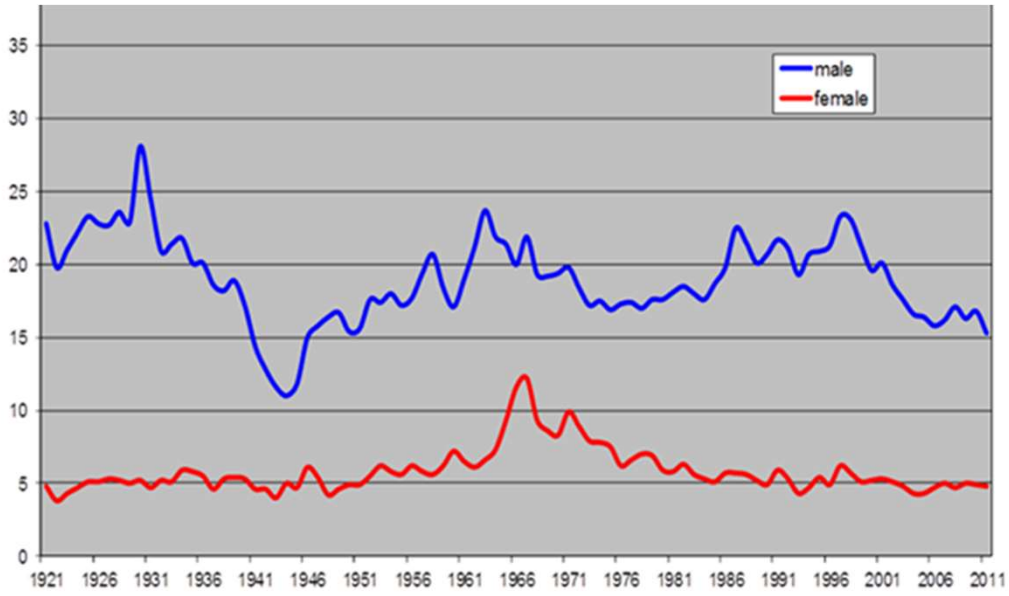
Determine the impact of personal values and attitudes about suicide on clinical practice and service systems

Therapeutic Alliance

Apply skills to guild a therpeutic alliance with a person who is suicidal and their family and consider systemic factors impacting on thier care

8

Suicide rates in Australia 1921 - 2011



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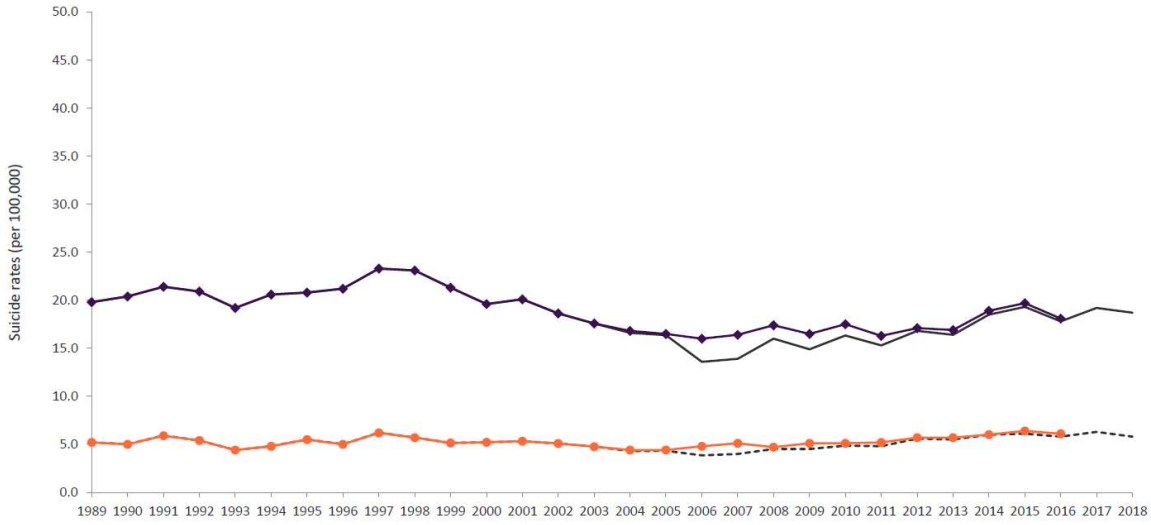
Age-specific suicide rates (1989-2018)



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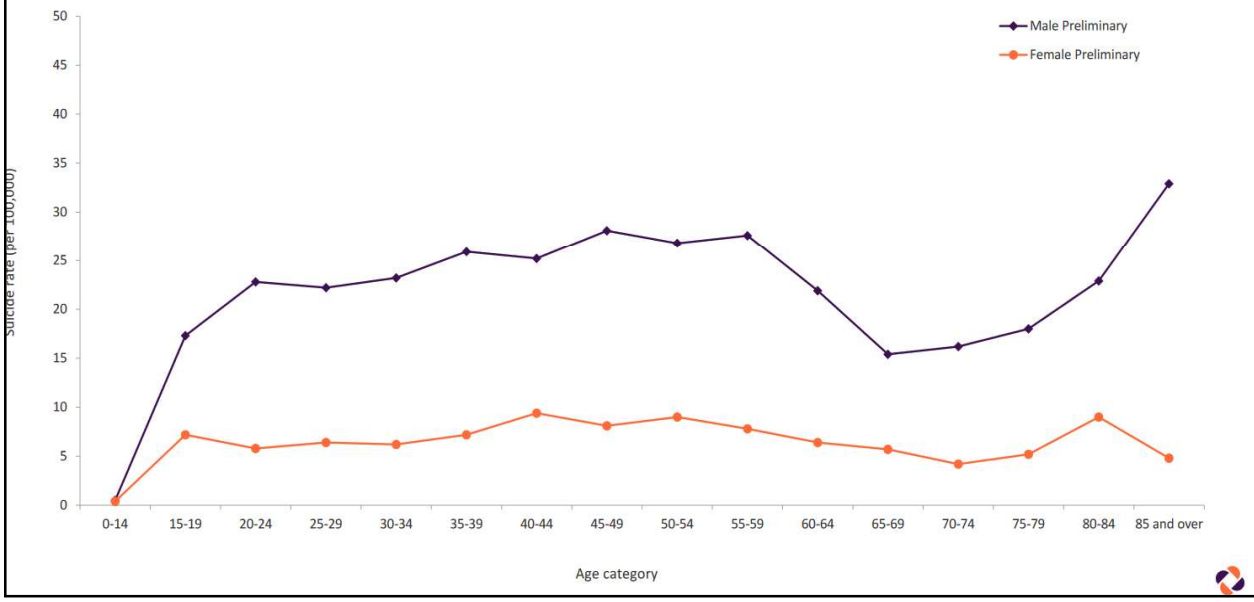
Preliminary age-specific suicide rates (2018)



Vulnerable Groups

- People who have previously attempted suicide (especially on discharge from care)
- People who engage in self harm
- People in custody
- Older persons
- People from CALD backgrounds, refugees and asylum seekers
- People living in rural and remote communities
- People with mental illness, especially during service transitions or when treatment is reduced
- People who identify as LGBTIQAP+
- Indigenous Australians

Engage

Treatment Engagement

Enhancing treatment engagement is critical given the stigma of suicide

- Attendance
- Continuation of care
- Understanding of therapeutic goals
- Level of involvement in therapeutic tasks

14

What could impact on the engagement people and assessment of suicide risk?

15

What could impact on the engagement and assessment of suicide risk?

Stage of life

- age/ageism
- brain deterioration
- cognitive capacity
- fatalistic attitudes
- loneliness isolation
- death of peers
- physical vulnerability – comorbidity
- diagnostic overshadowing

Systemic

- capacity
- values and attitudes
- culture
- family system
- care systems
- policy and legislation
- counter-transference

16

Systemic factors – young people

A closer look

Individual

- referred to treatment against their will.
- young person has different goals to adult who referred them.
- adolescence is a time of increasing autonomy. Therapy may not fit with this.
- fears around stigma and confidentiality.
- family conflict can be a precipitant of suicidal behaviour – if family brings child in for treatment this can create complex dynamics.

Family

- poor parent-therapist relationship.
- stressful life events.
- practical constraints, level of family conflict and parental physical health predict treatment attendance.
- cultural and familial factors that are incongruent with treatment: traditions, social norms, mistrust of the health care system, attitudes towards suicidality.

Systems

- waiting lists and delays in getting an appointment.
- cost of treatment.
- inability to switch therapists when requested.
- difficulties with communication between stakeholders (therapy provider, school, child safety, families and foster carers or residential settings).

17

"Powerful emotional reactions to a suicidal patient can fuel a pattern of defensive behavioural management that runs the risk of eclipsing the patient's suffering..."

- frustration and anger
- level of experience
- anxiety and fear
- clinician mental state
- personal experience
- exposure to suicide.

18

MB6

How would you modify your approach to work with a person from a different culture?

25

Guidelines	Examples
Build rapport, incorporate culturally appropriate interview techniques	Take breaks, slow down the process, explain the purpose of your assessment, check understanding, use simple language, use creative methods to engage the person and assist communication. Use an interpreter.
Ask about suicidal ideation, methods and plans	"Do things get so bad that you think about killing yourself?" "Have you had thoughts about not wanting to be alive anymore?" "Have you tried to kill yourself?"
Assess the persons understanding /beliefs about death, cultural implications associated with the suicidal act	"What do you think will happen when you die?" "Can someone return to life after they are dead?" "What do you think would happen if you did {stated method}? "Who do you know that has died?"
Ask about the precipitating event (s) – specific cultural stressors	"What was happening before you had these thoughts?" Use behaviour incident style questions to elicit concrete detail.
Assess family attitudes to the person and towards suicide	Gauge their level of anxiety, concern, whether they believe the person is at risk. Beliefs about mental illness, Willingness to be involved in safety planning.
Use multiple sources of information	Speak with GP, read files, school gather collateral information from a range of sources (recognising that other cultures have different family structures).

(Adapted from Anderson et al. (2019) and Diep et al., (2013))

20

Slide 19

MB6 Hi Dan. I've created an activity in the PW to accompany this slide. Please refer to PW.
Melissa Branjerdporn, 13/02/2020

Summary – Engage

- Assess the person's capacity to make decisions.
- Develop a trusting collaborative therapeutic alliance with the person and their family.
- Develop a shared understanding of the person's psychological pain and desire for suicide.
- Define a common goal for therapy that reduces the person's pain and feelings of entrapment and increases their capacity to cope.

QC54: Capacity Assessment Training and Advanced Health Directives

21

the Learning Centre

QC32: EARS Online

Assessing risk and protective factors for suicide

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Mobile Phone to silent

CPD Points

Technical support

Group Agreement

27

Learning outcomes

Risk Factors and Warning signs

Identify warning signs and static, dynamic protective, future and unknown risk factors

Understanding Suicide

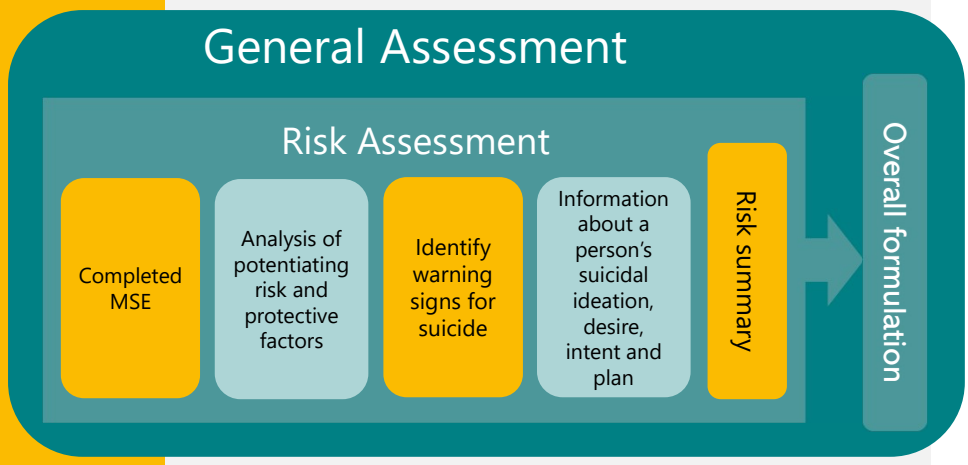
Apply the Integrated Motivational Volitional Model of suicidal behaviour to assessment and care planning

Care Planning

Develop a collarborative and person-centred care plan for suicidality

28

What is our focus today?



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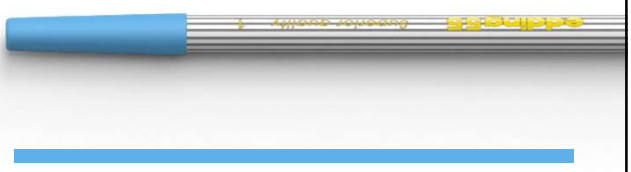
Assess

Risk and protective factors



Static	Fixed historical factors that increase risk.
Dynamic	Current factors that are exacerbating risk. They may fluctuate in intensity and duration.
Protective	Factors that mitigate or reduce a person's likelihood of a suicide attempt.

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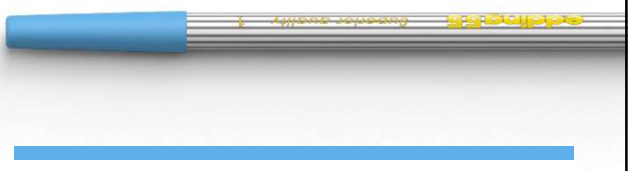
Risk and protective factors



Unknown	Factors that are not disclosed, or are unable to be assessed during an assessment.
Future / Critical junctures	Current factors that are exacerbating risk. They may fluctuate in intensity and duration.

32

Examples of risk factors in children (under 14)

Family	Individual	School and Peer related
Parental divorce	Interpersonal loss	Conflicts with peers
Poor communication with parents/carers	Disciplinary crisis	Bullying
Parent-child conflicts	Mental health disorder	Failed a grade
Family history of suicidal behaviours	Personality factors -irritability, impulsivity, and neuroticism	Suspended from school
Parental mental health problems/substance abuse	Poor problem solving	Dropped out from school

(Kolves, 2015)

33

Examples of risk factors in adults/older persons (over 65)

Adults		Older Adults	
Male	Alcohol use or abuse	Male	Social isolation/exclusion
Widowed, divorced, single	Past suicide attempt	Ill health, chronic conditions (esp pain)	Living in a nursing home
Unemployment	Childhood trauma	Functional impairment	Neuro-cog disorders
Legal difficulties	Family history of suicide	Retirement	Loss of autonomy
Mental Illness	Recent discharge	Bereavement	Elder abuse
		Mental illness	

Conejero, I., Olie, E., Courtet, P. & Calati, R. (2018), Koo, Y.W, Kolves, K & De Leo, D. (2016), Seele, I H., Thrower, N., Noroian, P. & Saleh, F.M (2017).

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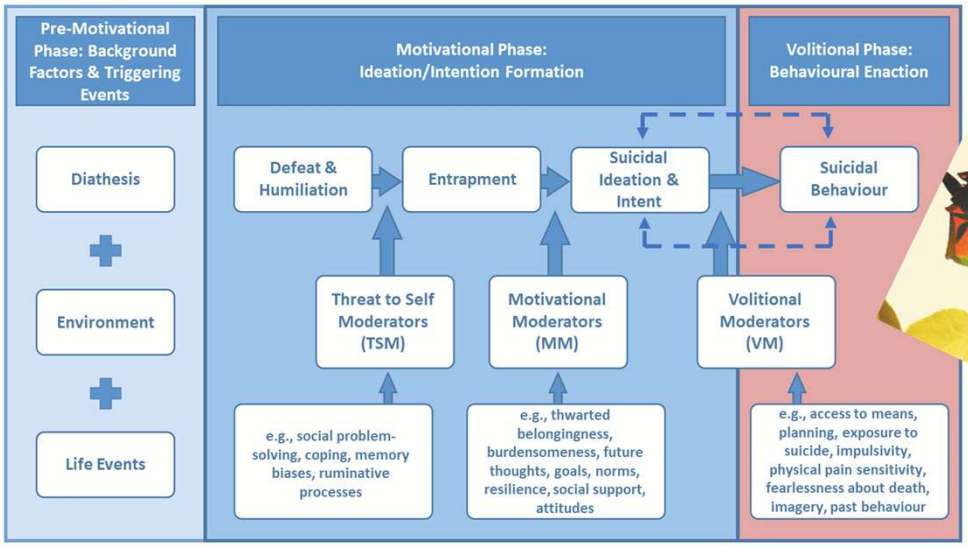
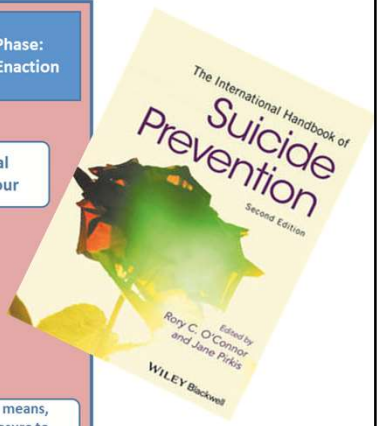
Break

15 minutes

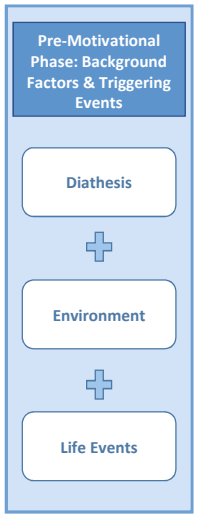
Integrated Motivational Volitional Model (IMV)





Pre-Motivational Phase

IMV



Static and dynamic risk factors that predispose a person to a heightened emotional state

- predisposing biological factors – brain maturation
- mental health history/illness
- personality traits – perfectionism/socially prescribed perfectionism
- low self esteem.

Contextual or systemic factors that may increase or perpetuate suicide risk

- peer conflict
- influence of social media
- academic pressures.

A triggering event or an accumulation of negative life events

- bullying
- relationship problems
- family conflict

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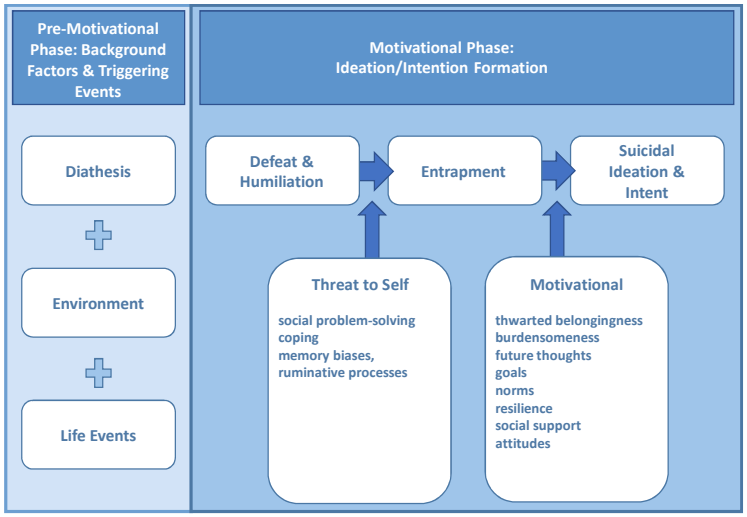
Motivational Phase

IMV



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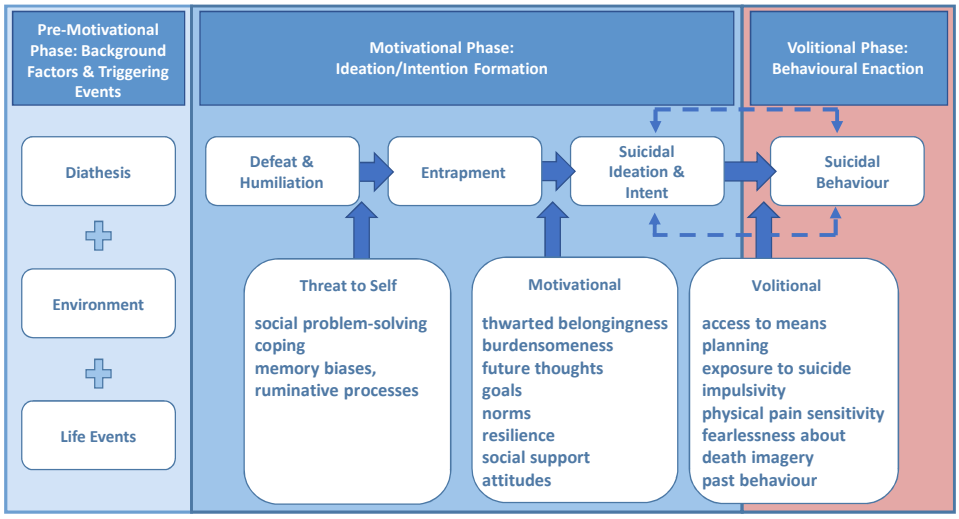
Volitional Phase

IMV



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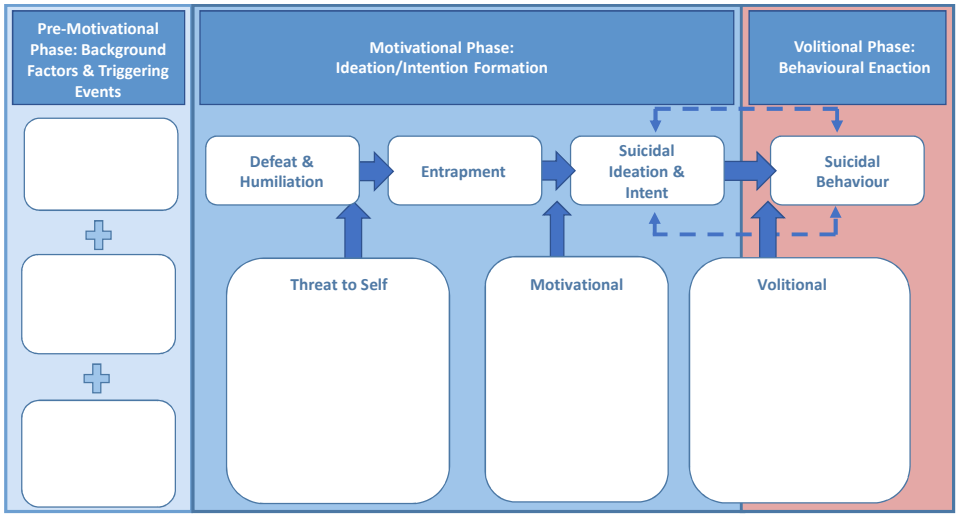
Simon's scenario

IMV



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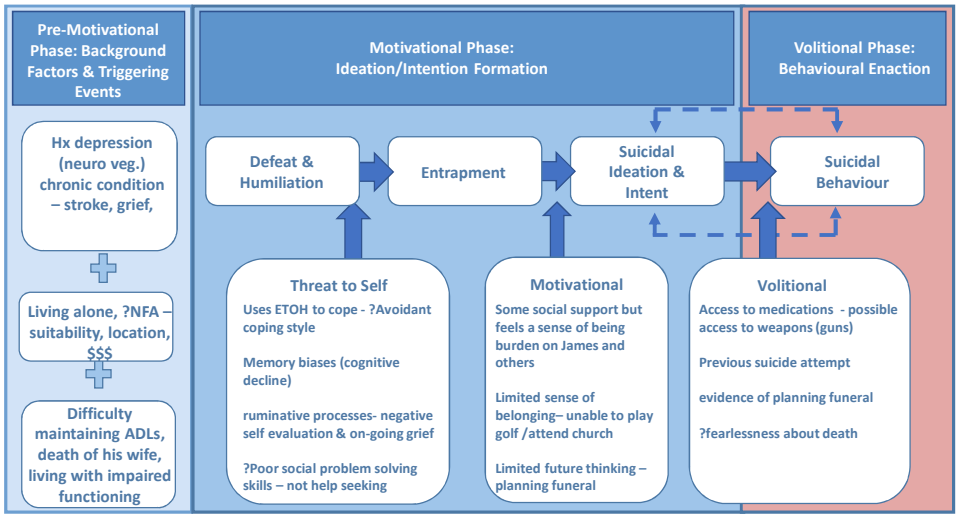
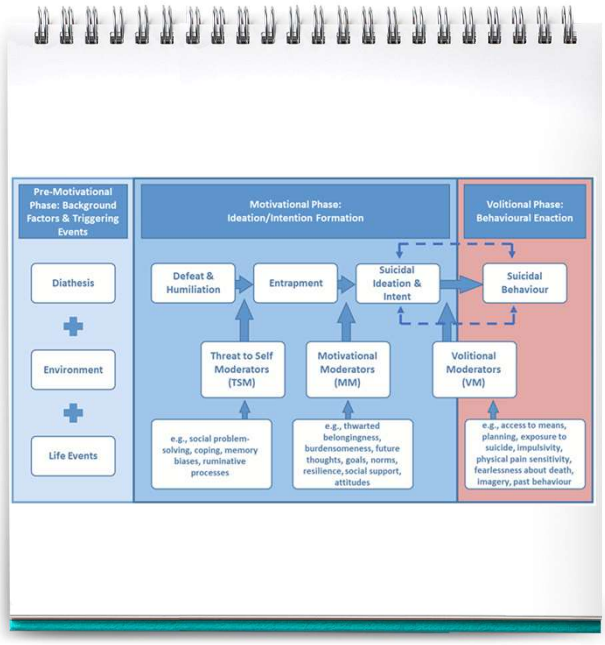
IMV



41

Activity: Assessing risk and protective factors

1. Allocate clinicians to break-out rooms
2. Use your completed IMV diagram
3. Develop clinical goals and strategies to target the moderators you have identified



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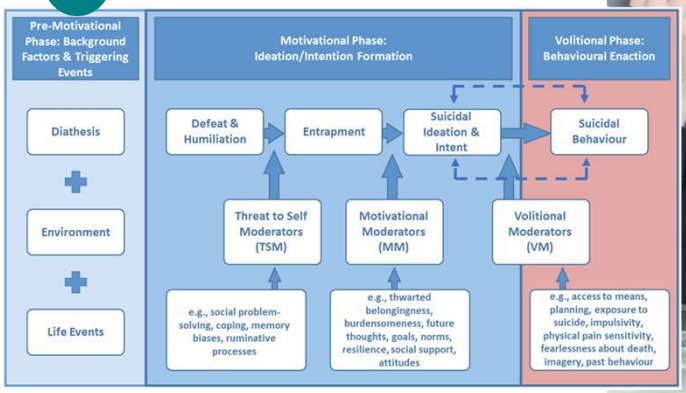
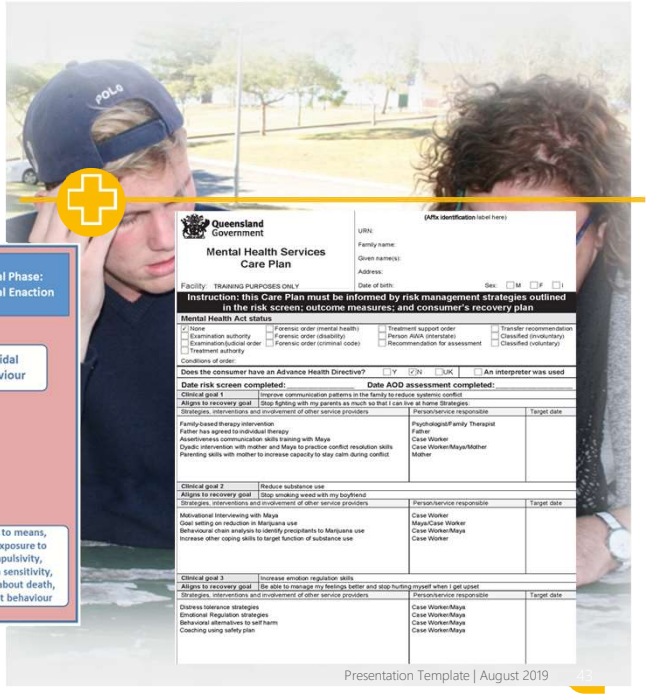
IMV informed care planning





Summary – Risk and protective factors

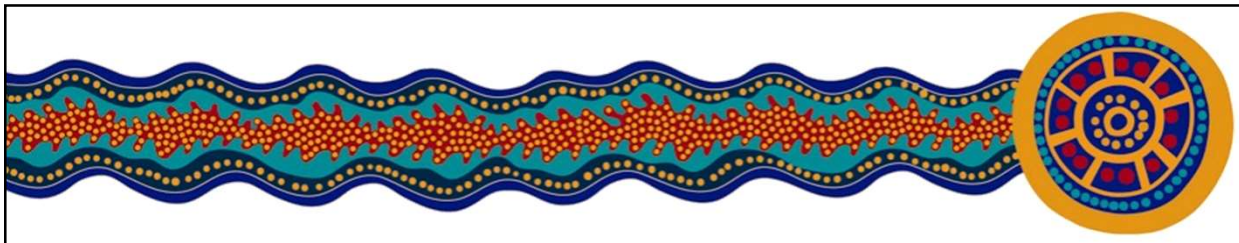
- Develop a shared understanding of the person's pain and factors contributing to their suicidal ideation
- Work collaboratively with the person to identify their recovery goals
- Use an evidence informed model to help identify areas to can target in treatment and develop clinical goals
- Consider the need for clinical escalation and consultation

QC55: Formulation and Planning

the Learning Centre

QC32: EARS Online

Assessing Suicidal Intent



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50

Learning outcomes

Assess suicidal intent

Apply the Chronological Assessment of Suicide Events approach to assess a young peron's suicidal ideation, planning, behaviour desire and intent

51

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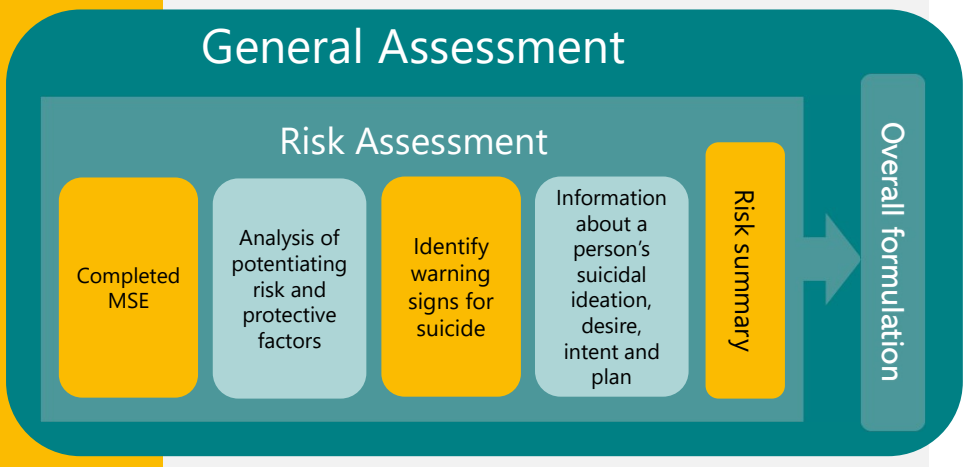

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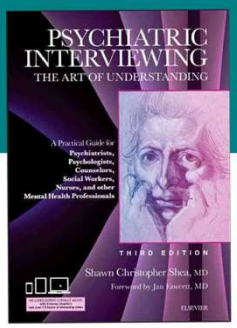
Group Agreement

- confidentiality
- emotional safety
- participation

53

Assessing suicidal intent

Chronological Assessment of Suicide Events (CASE)



(Shea, 2017)

Real suicide intent = Stated intent + Reflected intent + Withheld intent

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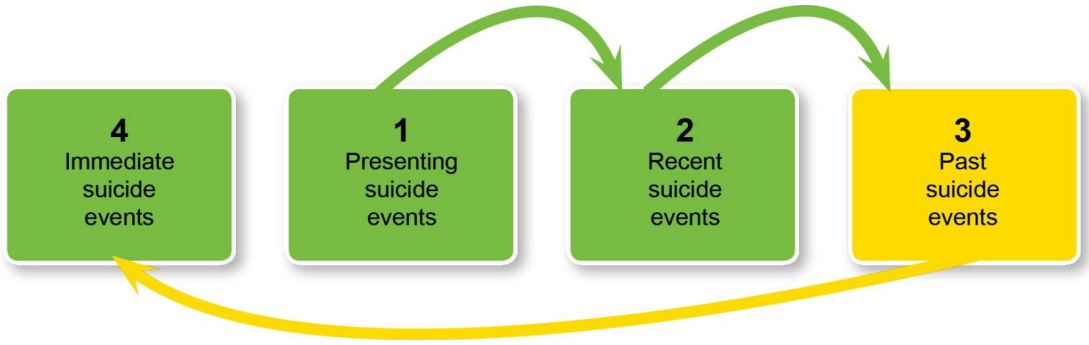
CASE Approach

Macro structure



(Shea, 2017)

55

CASE Approach

Uncovering suicidal ideation and intent

Shame attenuation [SA]	"Given all the pain you have been experiencing, I am wondering if you **have been having thoughts** of killing yourself?"
Normalisation [N]	"Some people I have worked with who have been through this have told me that they have thoughts of killing themselves, I am wondering if you **have been having** thoughts like that?"

56

Gentle assumption [GA]	"What **have you been** thinking of doing?"
Behavioural incident [BI]	**Facts:** "What were the tablets?" "How many did you have?" "How many did you take?" "Did you put the pills into your mouth?" **Sequences:** "What happened next?" "And what happened after you took them out of the packet?" "What stopped you?"
Denial of the specific [DS]	"Do you think about hanging yourself?"… *pause for answer…* "Have you thought about jumping from a building*?"…pause for answer…*
Symptom amplification [SA]	"How often do you think about hanging yourself…80-90% of the day?"
Catch all question [CA]*	"What other ways have you thought about killing yourself that we haven't talked about?"

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CASE Approach

Verbal video

Suicidal ideation

Gentle Assumption

What were you thinking of doing?

[Over the past two months] What other ways have you thought about killing yourself?

Anchor the verbal video

1. Method at hand *"Have you had the tablets out while having those thoughts?"*
2. Time – *When?*
3. Place – *Where?*
4. Summarising Invitation

Behavioural Incident

Facts – *lethal points? reflected intent?*

Sequences – *what happened?*

1. Uncover detail about the degree of reflected intent?
2. Where is the method now?
3. What stopped you?

58

Activity: Presenting and recent suicide events

1. Form pairs – in break out rooms
2. Turn to the next page of your scenario.
3. Role play these two time periods using the prompts in your PM

59

CASE Approach

Past suicide events

What was the psychosocial context of the past attempt?

- What is the most serious past attempt?
- What precipitated it?
- Was there a serious attempt within the last six months?

Where there any similarities between the person's worst point and now?

- Check the person's understanding of the reason for their past attempt (feelings of entrapment, burdensomeness, rejection)
- Are the current triggers or the person's current mental state similar to when the past attempt was made?

What new methods has this introduced into your assessment?

- Is this attempt clinically relevant to the current circumstances?
- Does it reflect higher lethality methods?
- What does this reveal about the persons capability for suicidal behaviour?

60

3 Past suicide events

Activity: Past suicide events

:

1. Read through the script provided of the clinician investigating the past events

2. Discuss and answer the questions in relation to your client on the table on page XX of the activity record

What was the psychosocial context of the past attempt?	
Were there any similarities between the person's worst point and now?	
What new methods has this introduced into your assessment?	

61

CASE Approach

Immediate Suicide Events

4 Immediate suicide events

What is the intensity of suicidal ideation/desire?

- Now (during the interview)?
- Anticipated at home?
- **Suicidal desire:** On a scale from 0 – 10, how would you rate your current pain/suicidal desire? (0 = no pain, 10 = I am in so much pain I want to die)
- **Suicidal intent:** how likely is it that you will try to kill yourself during the next week? (0 = no chance, 10 = extremely likely)

What is their level of hopelessness or entrapment?

- Do you feel things will get better in the future?
- How trapped do you currently feel, on a scale of, 0 being 'not trapped' and 10, being 'things will never change'?
- What things in life make you want to go on living?
- What would stop you from killing yourself?

Lead into collaborative safety planning

- Share you current formulation of risk
- Identify any future stressors or events that might trigger suicidal feelings/thoughts?
- What current resources does the person have to assist them to cope with future crisis?
- What contingency plans should be considered to support future safety?

62

Activity: Presenting and recent suicide events

1. In pairs – in break out rooms
2. Turn to the next page of your scenario.
3. Role play the prompts on the slide in the PW

63

[redacted]

64

Summary – Assessing Intent

- Maintain engagement throughout the assessment
- Ask directly about suicidal thinking and build a picture of the persons history of suicidal behaviour
- Consider information from other sources in your assessment
- Practice the techniques and make them your own

QC54: Foundations of Risk Assessment and Management

65

Break

15 minutes

the Learning Centre

QC32: EARS On-line

Risk summary and managing acute risk

Learning outcomes

Risk summary

Write a prevention orientated risk summary

Safety planning and brief Interventions

Develop a collarborative and person-centred safety plan for suicidality, including restricting access to lethal means

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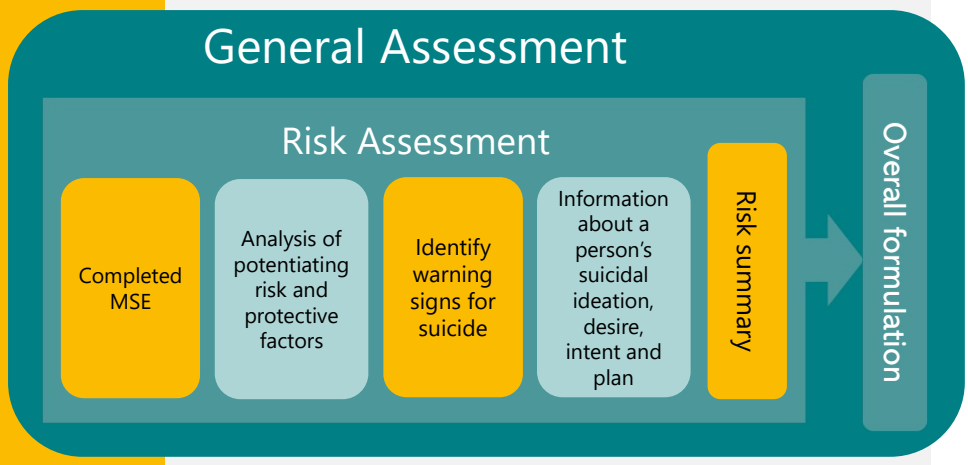

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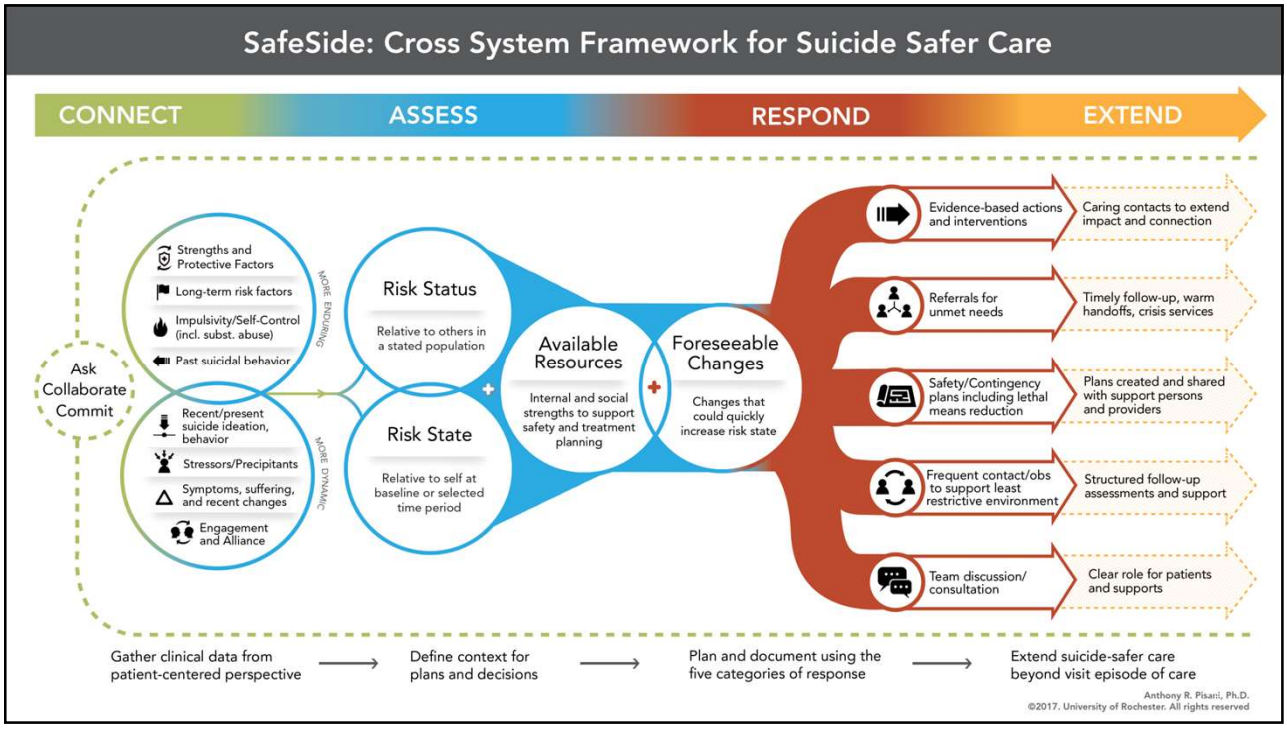

Activity Part A: Describing risk status and risk state

1. Review the Prevention Orientated Risk formulation model on page 56 of the participant workbook.
2. Based on the information contained in your scenario. Identify the more enduring and more dynamic factors that relate to the scenario
3. Describe risk status and risk state on page XX of the Activity Record

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Activity Part B: Identifying available resources foreseeable changes

1. In your groups, break into the roles of consumer, clinician, and observer/scribe.
2. The clinician will discuss the following with the young person:
   1. Sharing your risk summary with them
   2. Asking the person about and enquire into available resources in a crisis, and two foreseeable changes.
   3. Collaboratively develop contingency plans for these foreseeable changes.
3. The observer will document the available resources, the foreseeable changes and some of the contingency plans discussed.
4. After the role-play, we discuss short term interventions in the chat.

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Risk summary Gary

Overall assessment of risk and plans to mitigate risk (consider both static and dynamic risk factors for harm to the consumer and others, including chronic versus acute risk status, triggers, protective factors and warning signs. Mitigation strategies to address risks for the consumer and risks to family/carers and others. Strategies listed here must be included in the Care Plan)

Overview/impression	**Y**	**N**	**UK**
Person's level of risk appears to be highly changeable	✓		
There are factors that contribute to uncertainty regarding risk screen		✓	
A more comprehensive risk assessment is required		✓	

Gary's risk status is higher than the general population. He has had a recent suicide attempt (3 months ago), he has a family history of suicidal behaviour and been diagnosed with depression and anxiety. His risk status is higher than other outpatients in the community setting as he has made a recent suicide attempt. Compared to patients typically admitted as an inpatient, he is slightly lower as there is no psychosis, he has agreed to a comprehensive safety plan, and his wife is available to monitor him.

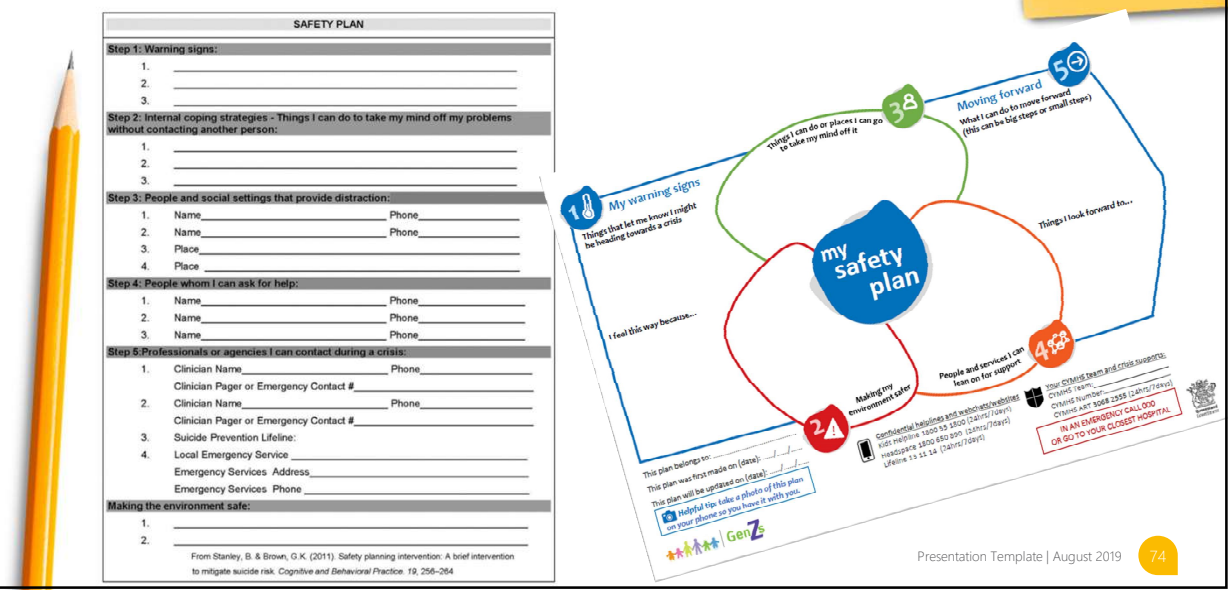
Gary's risk state is higher than before he sustained his back injury 12 months ago. His risk is higher than what it has been over the past 3 months as he has increased his substance use, and has experienced cut off from his daughter. He had also had a significant deterioration in functioning over the past two weeks.

However, Gary has some available resources to access in a crisis. He has available his wife who has agreed to monitor him closely, although she is also a stressor. Gary will need to see his GP regularly regarding pain management. If the GP is informed and educated abouts Gary's suicide risk, this could be an available resource, as Gary trusts his GP. Gary also now has a regular case manager whom he is starting to develop trust with.

Gary's risk state is likely to fluctuate based on some potential foreseeable changes. If Gary has another fight with his wife, and she threatens to leave, Gary's risk may increase. Gary also has a meeting with his boss next week, and if is unable to return to work his risk will increase.

Plans to mitigate risk:

Safety Planning - Stanley & Brown(2012)



SAFETY PLAN

Step 1: Warning signs:
1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:
1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:
1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:
1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:
1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline:
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

Making the environment safe:
1. _____
2. _____

From Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19*, 256–264

Lethal means restriction

A key part of every safety plan

Parents/caregivers/responsible adults need to be involved in removing access to medications, sharp objects, guns, weapons and other items that the young person may harm themselves with.

Prescribing practitioners should also consider the risk of accessible medication in terms of access to means

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Summary

- Share your risk summary with the young person and their family when appropriate – use simple language
- Provide referrals and treatment to address the underlying causes (drivers) of suicidal feelings
- Work collaboratively with the young person and their family to develop and document a safety plan, ensuring access to means is addressed
- Consider the need for clinical escalation and consultation

QC55: Formulation and Planning

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