MHPN
WEBINAR

Monday
23rd March 2020

Responding to the needs of a person presenting with suicidality

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Mental Health Professionals' Network

Tonight's panel

Dr Graham Fleming
General Practitioner

Professor Tim Wand
Nurse Practitioner

Dr Lyn O'Grady
Community Psychologist

Facilitator:
Ms Nicola Palfrey
Clinical Psychologist

Learning outcomes

Through an exploration of suicide risk the webinar will provide participants with the opportunity to:

- Define the concept of risk and known factors associated with increased risks of suicide.
- Identify the needs of a person experiencing suicidality, including assessment, risk formulation, safety planning and ongoing monitoring.
- Identify the importance of appropriate referrals and collaboration with other professionals when working with a person experiencing suicidality.

Beginning to understand suicide thinking

Three main components

- Sense of abject hopelessness and despair
- Delusion that suicide is the only or the best option
- Determination to die

Dr Graham Fleming
General Practitioner

Abject hopelessness and despair

- **Rapport**
- **Provide Hope**
  - acknowledge their feelings and their sense of despair
  - suggest there are options that negative minds cannot see.
- **Provide Support**
  - offer to help them find solutions to their situation
  - suggest counsellors, psychologists, social workers, financial advisers etc.
- **Provide resources**
  - Beyond Blue
  - card with emergency numbers, lifeline, local support services.

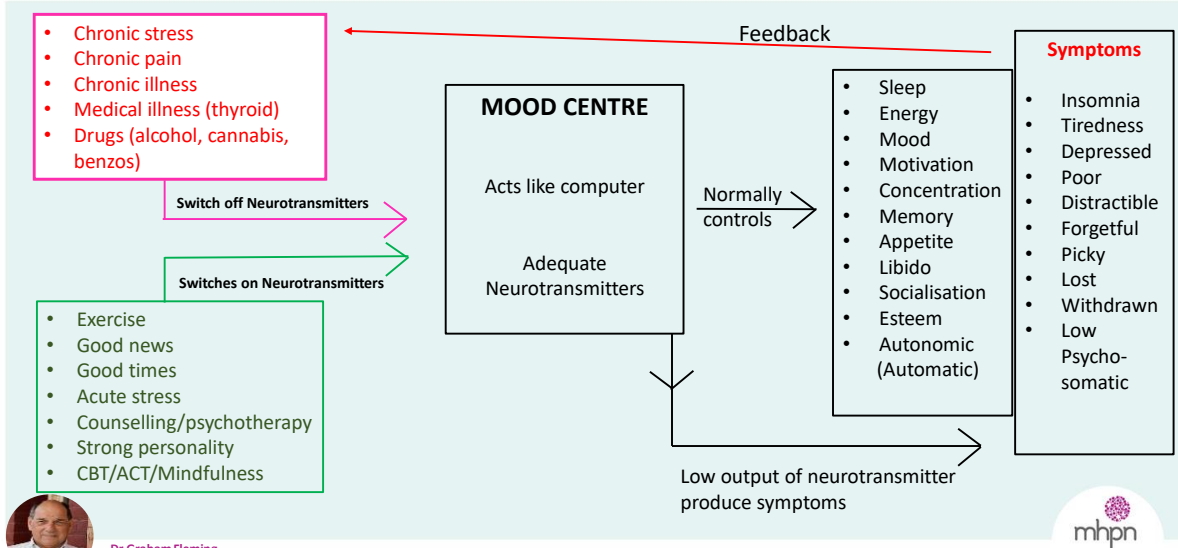
Dr Graham Fleming

Delusional thinking of suicide

- **Severe Acute Stress** or **Chronic Stress** can cause the brain to shut down
  - by reducing neuro-transmitters thus negative thinking only.
- **Inherited Biological Illness** is the more common cause.
- **Both** often cause or aggravate each other
  - as explained in following model.
- **Warn of triggers** particularly alcohol.

Dr Graham Fleming

Brain shut down (depression)



Determination to die

- **No-one is immune from the risk of suicide**
  - thoughts can come on very quickly and without warning.
- **Intrusive or ruminating Suicidal thoughts are not normal**
  - it is as life threatening as central chest pain.
- **Those with brain shut down (depression)**
  - have trouble understanding it much less explaining it.
- **Those with intrusive suicidal thoughts are very clever**
  - at hiding it from themselves and particularly those close to them.
- **Recovery from poor mental health is a risk period.**


Dr Graham Fleming

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Suicide risk assessment

- While thoughts of suicide are common, the act of suicide is statistically rare.
- *A normal response by normal people to an abnormal situation* (Henden 2008)
- There is no evidence that a focus on risk factors (such as plans or means) has any impact on circumventing suicide (Large et al., 2011).
- No evidence that risk stratification 'high, medium or low' has any clinical utility.
- Carter et al., (2017) only 5.5% of patients classified as "high risk" can be expected to suicide after long periods of follow-up. That 95% of 'high risk' suicidal patients do not go on to end their lives illustrates how challenging the task of suicide risk assessment is.
- Most suicides occur in 'low risk' populations for the simple reason that this group consist of many more members than the 'high risk' category (Wand 2012)
- Any form of risk stratification is unwarranted for determining the need for clinical services or follow-up (RANZCP 2016)
- In this case Nathan was deemed 'medium risk' how is this determined, and for how long? Risk fluctuates!

Tim Wand
Nurse Practitioner

Suicide risk screening

Australian Commission for Healthcare Safety and Quality (2018)

- A lack of effective and well-validated screening tools for suicide risk with no evidence that such tools are able to accurately predict suicide risk or differentiate suicide risk from self-harm.
- Risk screening and assessment have become a formality. People are screened multiple times for the same risk, leading to duplication of effort and work, and poor patient experience.

Tim Wand

Suicide risk screening

United Nations Special Rapporteur (2019)

- There is insufficient support that screening can identify individuals at risk for suicide and prevent them from acting. A large percentage of suicide attempts are impulsive and unplanned in a moment of acute despair. Regular screening and monitoring are unlikely to prevent such cases.
- People with a mental health condition, drugs or alcohol problems, experienced trauma and loss, and those who are facing acute stress at work or in their relationships, are at increased risk for suicide.
- There is a growing body of research to suggest that excessive reliance on biomedical interventions, including antidepressants and voluntary and involuntary hospitalisation, may have a counterproductive effect and lead to increased suicide risk.
- Interventions focused on building coping skills, and which emphasise the unique experience of the individual show much more promise and must be prioritized.

Tim Wand

Suggestions for working with Nathan

- Acknowledge the distress this situation has caused him.
- normalise the suicidal thoughts (not minimise them) as an understandable symptom of his distress
- focus on how willing Nathan is to explore options other than suicide
- talk about self-care not self destruction
- connection not isolation
- health oriented activities that shift attention
- discuss ways of keeping safe.
- instill hope.

Tim Wand

Hearing Nathan's story

- 30 years old, male
- Relationship break down – breach of trust, confusion, mutual friends, having to return to live with parents after 10 years of living independently
- Losing interest in life – disconnected from mates, not motivated to work, longstanding conflict with parents
- Shame about suicide attempt – parents' belief that suicide is sinful, a 'real man' should be able to cope
- Impulsivity, always done risky things
- Not knowing himself now – being 'bad mouthed'
- Nightmares – 'feeling haunted' by the suicide attempt – stress/trauma responses
- Life has reached rock bottom – nothing to live for but has no current thoughts or plans. He doesn't want to die but doesn't trust himself. He doesn't know himself anymore.
- Bethany, younger sister, is a supportive person and he can talk to her

Dr Lyn O' Grady
Community Psychologist

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Mental health professional's response

Typical (unhelpful/panicky) thoughts	More helpful thoughts
Is he at risk?	He is at risk, although not imminently. I need to work with him to develop a safety plan.
What if he's not telling me everything?	He's possibly not telling me everything. We need to do safety planning.
Am I the best person to help?/I'm not able to help.	He's here with me. I can listen, validate, help him develop safety planning and talk with him about who else can help.
I'll have to make sure he comes back to see me/I'm totally responsible for his safety and wellbeing.	I hope he will come back but I need to work with the reality of my role, be as professional and supportive as possible to increase the likelihood he'll seek help again and focus on safety planning that includes a range of supports.
He's feeling hopeless. How can I give him hope?	I can hear his story (psychache), look for glimpses of hope and help him identify one or two achievable things that he can do today and tomorrow.
What if I mess up? Miss something?	I have a process I can work through. I know what to do. I will do the best I can within scope of my practice.

Dr Lyn O' Grady

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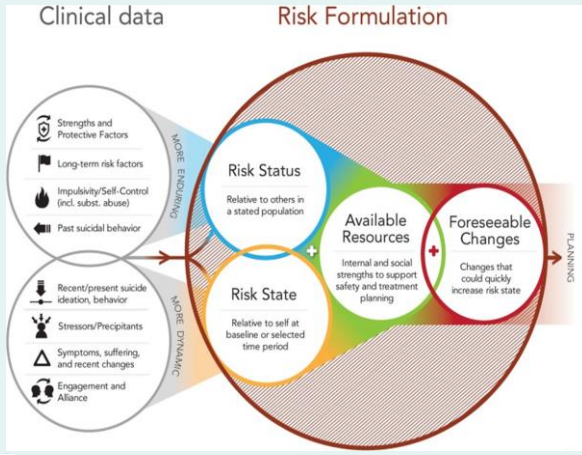
Risk formulation



What else do I need to know?

- Past suicide attempts/unsafe behaviours
- Contact with any people who died by suicide?
- Alcohol or other substance use?
- Other supports?
- His strengths/ways of coping?
- What matters to him/what gives his life meaning?

Dr Lyn O' Grady

Role of family or friends

"Family or friends are usually the main source of support for a person in suicidal crisis and are desperate to do all they can to help, to keep their loved one safe. It's an extremely challenging and frightening time but it helps to be equipped with relevant information and actively involved in support planning. These guidelines set the standard for ensuring everyone who presents at emergency, including their family or friends, are treated with dignity and respect, receive practical support and appropriate referrals to the care they need to recover."

Bronwen Edwards, CEO, Roses in the Ocean and lived experience adviser

Dr Lyn O' Grady

Safety planning

https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning

Safety First – not last! Suicide Safety Planning Intervention: Glenn Melvin, Daniel Gresham & Susan Beaton Inpsych article: https://www.psychology.org.au/inpsych/2016/feb/melvin/

- Reduce the likelihood that suicide can occur
- for example: contact support person, hand over pills to family, don't leave the person alone
- hear the pain and encourage hope
- identify cognitive distortions
- work on problem solving
- link to resources ie. mental health, hospital, family etc.
- explore prior coping skills
- detaching from emotional pain (grounding)
- mindfulness.

Dr Lyn O' Grady

Q&A Session

Dr Graham Fleming
General Practitioner

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Community Psychologist

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Upcoming webinars

In partnership with Emerging Minds:

Supporting Trans and gender diverse children and their families, Thursday 23rd April 2020

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Thank you and good evening