An interdisciplinary panel discussion

A Collaborative Approach to Supporting People at Risk of Suicide

Monday, 13th May 2013

“Working together. Working better.”

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists
This webinar is presented by

Panel

• Dr Timothy Wand (Mental Health Nurse Practitioner)
• Dr David Webb (Suicide Survivor)
• Ms Susan Beaton (Psychologist)
• Dr Michael Dudley (Psychiatrist)

Facilitator

• Dr Mary Emeleus (General Practitioner)
Ground Rules

To help ensure everyone has the opportunity to gain the most from the live webinar, we ask that all participants consider the following ground rules:

• Be respectful of other participants and panellists. Behave as if this were a face-to-face professional development activity.

• Please post your comments and questions for panellists in the ‘general chat’ box. For help with your technical issues, please post in the ‘technical help’ chat box. Be mindful that comments posted in the chat boxes can be seen by all participants and panellists.

• Your feedback is important. Please provide your feedback by completing the short survey which will appear as a pop up when you exit the webinar.
At the end of the session participants will be better equipped to:

• Raise awareness of the indicators and stigma associated with suicidality

• Identify the key principles of the featured panellists’ approach in assessing, treating and supporting people at risk of suicide

• Identify the merits, challenges and opportunities in providing collaborative care for people at risk of suicide
Mental Health Nurse Perspective

**Issues to consider**

- Challenging developmental background
- Family disruption
- One OD in the past
- Previous involuntary hospitalisation
- Anxiety and stress
- Sleep

Dr Timothy Wand
Mental Health Nurse Perspective

**Positives**

- Despite adversity Caitlin has managed to support herself and get into Uni. 3rd year!
- A seemingly significant period of wellness
- Caitlin looks after her health
- Self-efficacy and resilience
- No substance misuse issues evident
- Resources- mother, friends, Caitlin’s motivation
Mental Health Nurse Perspective

Assessment and assistance

• No evidence for the effectiveness of risk assessment in self-harm suicide reduction
• ‘Even more worried’
• Normalise not pathologise the situation
• ‘Crying for no reason’
• ‘Not her usual cheerful self’
• Assessment of strengths, assets and abilities
• Health education, symptom management
• Sleep

Dr Timothy Wand
Mental Health Nurse Perspective

**Collaboration**

- Competing risks - resentment, demoralisation, loss of income, missing University and falling behind.
- Mother and family
- Friends
- University - letters of support
- Colleagues and services - support, information sharing and differing perspectives
Suicide Survivor Perspective

The socio-cultural context

- Prevailing response to suicide - PANIC - fear, ignorance and prejudice
- Stigma = discrimination - i.e. belongs with those who discriminate against us
- Likely pathway (for Caitlin?) - diagnosis, hospitalisation, coercion, forced/unwanted “treatment”
- The politics of suicide (prevention) - power hierarchy of suicide prevention industry
Suicide Survivor Perspective

What's missing, what's needed?

• Respect for (rather than judgement of) the suicidal person
• Whole person (holistic) approach - suicide as a “crisis of the self”
• Sanctuary, asylum, refuge (e.g. Maytree, UK)
• Spiritual dimensions of suicidality - causes and/or recovery
• Demedicalise and "decriminalise" suicide - human rights versus "duty of care”
• Move beyond "evidence based" paralysis
• Genuinely collaborative approach - doctors on tap, not on top (cf. mental health versus drug and alcohol)
• Include first-person knowledge - Nothing About Us Without Us
Suicide Survivor Perspective

Caitlin

- Risk assessment 1 - gold standard (Aeschi Group) is to ask her (all other "indicators" are secondary/clues)
- Risk assessment 2 - the danger she faces from mental health system
- Unhelpful language - assessment, diagnosis, illness/sickness/disorder, treatment, relapse etc
- Recognise your own fears, judgements, prejudices etc
- Capacity to "bear witness" - without judgment, resisting urge to advise/solve/fix (saviour complex)
- Do not feign false empathy
- Most of all, respect and honour her intensely important, meaningful (and sacred) crisis
“I have never before read anything relating to suicide that speaks of suicidal feelings as being worthy of respect. The possibility that I may actually be able to honour these feelings is a totally new concept, one which has proven to be a catalyst for change and personal growth.”

Josephine Williams, suicide attempt survivor [from back cover of "Thinking About Suicide"]
"If I am suicidal, I want a therapist who believes I’m going
to live, not die.

Even if I am chronically suicidal and have only a smidgen
of ambivalence between me and a lethal attempt, I don’t
think I need a healer who has already quit on me."

- Dr Paul Quinnett
Psychologist Perspective

**Risk Factors**

- Previous suicide attempt
- Relationship breakup – loss
- Low mood – potentially suffering from depressive symptoms
- Age – not fully developed PFC (could influence impulsivity and decision making)
- Loneliness, isolation from friends
- Lack of sleep
- Loss of appetite
- Ruminating
- Cognitive functioning impaired
- Panic attack
Psychologist Perspective

Protective Factors

- Continued with education despite difficult times – perseverance
- Achieved well to get into Physiotherapy
- Improved relationship with Mo
- Problem identification
- Help-seeking
- Attending gym
- Keeping up with job
- Faced previous adversity and recovered
1. The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality
2. The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect
3. The interviewer's attitude should be non-judgmental and supportive
4. The interview should start with the patient's self-narrative
5. The ultimate goal must be to engage the patient in a therapeutic relationship
6. We need new models to conceptualize suicidal behaviour that provide a frame for the patient and clinician to reach a shared understanding of the patient's suicidality

Psychologist Perspective

Collaborative Assessment and Management of Suicidality (CAMS)

Managing Suicidal Risk
A Collaborative Approach

Ms Susan Beaton
Psychologist Perspective

TRADITIONAL "MEDICAL" MODEL

DEPRESSION
- LACK OF SLEEP
- POOR APPETITE
- ANHEDONIA ...
- ? SUICIDALITY ?

THERAPIST

PATIENT

COLLABORATIVE APPROACH

SUICIDALITY
- PAIN
- STRESS
- AGITATION
- HOPELESSNESS
- SELF-HATE

THERAPIST & PATIENT

RESPECT FOR LIVING VS. RESPECT FOR DYING

Figure 1. Traditional (medical model) assessment of suicide risk versus Collaborative Assessment and Management of Suicidality (CAMS).
THE CAMS APPROACH

SUICIDALITY

PAIN | STRESS | AGITATION

HOPELESSNESS | SELF-HATE

REASONS FOR LIVING VS. REASONS FOR DYING

Mood

THERAPIST & PATIENT

Psychologist Perspective

Ms Susan Beaton
Sample Safety Plan

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<th>Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:</th>
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<th>Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):</th>
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<th>Step 4: People whom I can ask for help:</th>
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<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
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<td>1. Clinician Name ______________________ Phone ____________________</td>
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<td>Clinician Pager or Emergency Contact # ______________________</td>
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<td>2. Clinician Name ______________________ Phone ____________________</td>
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<td>Clinician Pager or Emergency Contact # ______________________</td>
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<tr>
<td>3. Local Urgent Care Services ______________________</td>
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<td>Urgent Care Services Address ______________________</td>
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<tr>
<td>Urgent Care Services Phone ______________________</td>
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<tr>
<td>4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)</td>
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<th>Step 6: Making the environment safe:</th>
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The one thing that is most important to me and worth living for is: ______________________

Ms Susan Beaton
Psychologist Perspective

Suicide Mitigation, Alys Cole-King

“Risk assessment should be seen as a therapeutic intervention with the potential to save lives rather than an information gathering exercise. Instead of focusing on simply quantifying and characterizing risk, the emphasis should be on identifying patients’ needs and empowering them to accept help, reducing their distress and maximizing protective factors and reasons for living through co-creation of a risk mitigation plan and the instillation of hope.

Suicide mitigation, originally proposed by Cole-King and Lepping, promotes practitioners and carers to engage and collaborate with patients in a positive person-centred therapeutic relationship to diligently assess and mitigate risk (Cole-King and Lepping, 2010b). The concept of suicide mitigation is, as the authors suggest, a paradigm shift in the assessment of and response to suicidal individuals.”


Ms Susan Beaton
Psychologist Perspective

Coping with Suicidal Thoughts

I’m seriously thinking about suicide. What should I do?

If you are thinking about suicide, you are not alone. Many people have thoughts of suicide, for a number of reasons. Thoughts of suicide can be very scary. You probably feel hurt, confused, overwhelmed and hopeless about your future. You may feel sadness, grief, anger, guilt, shame, or emptiness. You may think that nothing can be done to change your situation. Your feelings may seem like they are just too much to handle right now. It is important to know that thinking about suicide does not mean that you will lose control or act on these thoughts. Having thoughts of suicide does not mean you are weak, or ‘crazy’. Many people think about suicide because they are looking for a way to escape the pain they are feeling.

Even though your situation seems hopeless and you wonder if you can stand another minute of feeling this bad, there are ways to get through this and feel better. You don’t have to face this situation alone. Help is available. Here are a few ideas that you can use right now.

**Connect with others:** If you are worried that you may lose control or do something to hurt yourself, tell someone. Make sure you are around someone you trust. If you live alone, ask a friend or family member to stay with you. If you don’t know anyone or can’t reach friends or family members, call 1-800-SUICIDE (1 800-784-2433).

**Keep your home safe by getting rid of ways to hurt yourself:** It is important to get rid of things that could be used to hurt or kill yourself, such as pills, razor blades, or guns. If you are unable to do so, go to a place you can feel safe.

**Develop a safety plan:** It is very helpful to have a written safety plan when you have thoughts of hurting yourself. Have a trusted family member, friend, or professional help you to complete this safety plan. Keep this plan somewhere you can see or find easily. Write down the steps you will take to keep yourself safe (see the following example). Follow the steps. If you follow these steps and still do not feel safe, call a crisis line, get yourself to a hospital emergency room or call 911.

Dr. Joel Samra, R.Psych, and Dr. Dan Blasier, R.Psych. (Lead Authors, 2007), Consortium for Organizational Mental Health (COMH: www.comh.ca), Faculty of Health Sciences, Simon Fraser University, Vancouver, BC. Inquiries may be directed to: info@comh.ca.

This document is not intended to replace professional care with a therapist or physician.

Ms Susan Beaton
Psychologist Perspective

Working with the Suicidal Patient
A Guide for Health Care Professionals

Summary
- Assess/Crises Safety
- Build Rapport – introduce yourself, your role, your goals
- Assess Current Suicidal Ideation
- Obtain Details of Current Attempt (if applicable)
- Obtain History
- Communicate with Family/Friends

Refer to Mental Health/Psychiatry if High Risk

Task One: ASSESS

1. Assess current suicidal ideation

Is suicidal ideation present now?
- Have you gotten to the point where you didn’t want to go on? Have you had thoughts of not wanting to be alive? What about right now?

Passive Ideation: The patient would rather not be alive, but does not indicate a plan that involves an act of initiation = LOWER RISK (e.g., I’d rather not wake up in the morning; I wouldn’t mind if a car hit me when I was crossing the road)

Active Ideation: The patient has acute thoughts of completing suicide = HIGHER RISK (e.g., I think about killing myself; I feel like throwing myself into the matter)

Intense, continuous ideation = HIGHER RISK

Is there a plan?
- Do you have a plan as to how you would end your life?

Detailed, carefully thought-out plan = HIGHER RISK

Is there intent?
- You talk about wanting to die, and have even considered taking pills but are you intending to do this?

Low Intent: Suicidal thoughts and fantasies about plans, with absolutely no intent to put these plans into action. Fantasizing about suicide can provide some comfort to those in distress to know there is always a way out = LOWER RISK (e.g., Oh no, I could never do that, I have children)

High Intent: Expression of specific intent to end life — HIGHER RISK (e.g., I need to do this as soon as my daughter’s graduation is over)

Ambivalent or Unclear Intent: Ask about what has helped in past. What has stopped you from ending your life so far? What has helped in the past when you’ve had these thoughts?

2. Obtain details if there is a suicide plan

How lethal is the plan?
- How lethal does the patient believe the method to be?

Is there access to means?
- Obtain specific details.

What pills do you have or would you take to overdose? Exactly where would you get a gun from?

Has patient chosen a time and/or place?
- How isolated is the patient? What preparations have been made (e.g., buying rope)?

Has patient made final arrangements?
- Has patient prepared a suicide note, settled their affairs or communicated to others?

Higher lethality, access to means, preparations and arrangements = HIGHER RISK

Note: This document is intended to be a guide to working with the suicidal patient and should not replace a psychiatric consultation. When suicidal risk exists, an expert opinion should be sought to determine the need for hospitalization and clarification of diagnosis.

Ms Susan Beaton

MHPN
Mental Health Professionals Network
Psychologist Perspective

Building a Therapeutic Alliance With the Suicidal Patient

Edited by Konrad Michel and David A. Jobes

Ms Susan Beaton
Psychologist Perspective

Suicide Care in Systems Framework

National Action Alliance: Clinical Care & Intervention Task Force

In 2011, we set out to identify the best practice toolkit for better suicide care. What we found most compelling were the cultural and system changes that were common in the most innovative suicide intervention programming. This thought paper lays out a logic map model for replication.
Few voices of suicide attempt survivors have emerged in the public conversation about suicide, and few resources exist for us and for those who’ve wrestled with suicidal thoughts. We wanted to create a space that people and those who love them can stumble across while Googling answers to those lonely questions, “Has this ever happened to anyone else?” and “What do we do now?”
“The Reasons to go on Living Project is designed to understand how people’s thinking changes after a suicide attempt. We do not understand the thinking processes that occur for people who choose to go on living after an attempt and there is very little research in this area. We believe that if we had a better understanding of how people found the strength to go on living after an attempt, we might be able to better help people who are thinking of ending their lives, before they make an attempt.”
Acknowledgements

Susan Beaton, Bob Goldney, David Webb, Jagoda Pasic and colleagues, at WPA Prague 2012, modified)
Psychiatrist Perspective

**Suicide: epidemiology**

- A tragic, preventable global health issue
- In Australia, it leads causes of death by injury, and causes of death for 15-44 year olds
- Despite decreases since 1997, rates from 2002 to 2007 were 30-40% under-reported
- Suicide attempts and self-harm are not only a major public health and clinical problem, but a barometer of how well we care as a society
Psychiatrist Perspective

What makes people suicidal?

- Unbearable psychological pain and cognitive constriction (Schneidman, 1993)
- The wish to die involves failed belongingness and perceived burdensomeness (the misperception one’s death will relieve others), and acquiring the capacity to lethally self-injure (Joiner, 2005, 2009)
- What does stigma contribute?

Dr Michael Dudley
Public doubt about preventing suicide

• Public scepticism about suicide prevention (SP)—¼ thought that suicide was not preventable, 1/10 were undecided (Lifeline Newspoll 2009)

• Scepticism about SP applies to intervening with non-clinical groups, as well as patients
Psychiatrist Perspective

Doubt & disconnection among health professionals

- Health professionals sometimes doubt SP (e.g. Morgan and Evans (1994) – 20% thought SP was infeasible)
- One Australian study found treatment satisfaction for suicide attempt survivors as mixed for 1/3 and poor/very poor for 1/5; 28% reported attitudes of hospital health professionals as mixed and 33.5% as poor or very poor (De Leo et al., 2005)
Stigma about suicide

- ‘Those who talk about it don’t do it’
- ‘Don’t talk about it: it’ll give them ideas’
- ‘There’s no point intervening: people who are determined will just do it anyway’
- ‘They’re cowards’, or ‘they’re selfish’, or ‘they’re seeking revenge’ etc etc (see Thomas Joiner’s ‘Myths about Suicide’ (2010))
- Stigma comprises illiteracy, prejudice and practices
- Role of ambivalence
Stigma and trauma constrain help-seeking for suicidality

- By young people and young men in particular but also various marginalised groups and suicide-bereaved people and suicide attempt survivors, who do not receive continuing treatment – and also those like Caitlin who have been ‘burnt’ by the psychiatric system.

Dr Michael Dudley
Psychiatrist Perspective

**Constraint of professionals**

- Fear and organisational demands may elevate risk assessment (which cannot predict suicidal acts) above therapeutic relationships
- Organisations, doctors & psychiatrists (especially) may be blamed or sued for negligence, resulting in untold financial and emotional costs and defensive practice
- Accurate documentation of psychosocial and risk assessment is needed. Standards of care must be reasonable and prudent (Berman, 2006)
- However, pressure to fulfil (medico-legal) ‘duty of care’ can also be in tension with the patient’s human rights
What specific interventions are available/skills are required?

- No specific anti-suicide therapies exist (problem-solving therapy = same as usual care (Hatcher et al, BJP, 2011). Leading groups (e.g. NICE guidelines, Royal College of Psychiatrists and RANZCP) do not recommend any definitive intervention.

- Trained communities and individuals who engage with the person’s distress in pragmatic and timely ways and who offer hope and compassion can be as effective as paid helping professionals in sustaining life. Connection is critical.
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Starting and staying with the person

• Various gps and individuals are reclaiming the precept of listening to & learning from suicidal persons: building relationships through courtesy and respect, clear explanations of process and content, and delivering on what is promised.

• Avoid medicalising, as drug companies & sometimes psychiatry do - Use psychiatric language and diagnosis where needed but if possible sparingly; and avoid the pitfall of using taxonomies to classify people (trust in psychiatric taxonomies and ‘evidence-based’ psychiatry? – maybe a topic for discussion!)
Psychiatrist Perspective

**Psychosocial (including risk) assessment**

- Clinical risk assessment and categorisation cannot predict suicidal actions
- But the practice of psychosocial (including risk) assessment underpins a comprehensive approach to care
- While routine A& E assessment can prevent self-harm – Level 3 (case-control) evidence – A&E’s also can be unfriendly places: illiterate and censorious about self-harm, poorly informed about services, and poorly organised for follow-up – so that people can be alienated and lost without trace.

Dr Michael Dudley
Psychiatrist Perspective

Hence, improve staff knowledge and confidence

Because:

• Lack of staff knowledge about self-harm
• Poor communication between staff and with the patient
• Sub-optimal post-discharge follow-up
• And lack of knowledge of and access to services,
• Can also contribute to poor outcomes.

Dr Michael Dudley
Psychiatrist Perspective

Diagnosis = science, culture, marketing, exercise of power

• Clinical depression is not as common as drug companies and some national awareness programs would have us believe. But:
  • Its melancholic form (= ‘moderate-severe major depression’ (DSM)?) has an ancient pedigree
  • Clinical depression is qualitatively different to sadness or grief (a differential diagnosis for Caitlin), it is disabling, potentially dangerous, occurs with other conditions (e.g. eating disorders (Caitlin?)) and is often inadequately recognised and treated before and after suicide attempts. It needs to be detected
Psychiatric hospitalisation

- Psychiatric – including compulsory – hospitalisation reportedly (in Level 3 (cohort & case-control) studies) reduces suicide risk but its hidden injuries are rarely examined or discussed.

- To doctors: don’t admit, treat, seclude or restrain people against their will unless there is absolutely no less restrictive alternative. Explain decisions, work with patient and staff to maintain her control and prevent hospital-induced trauma, explicitly inform the patient of her rights and promote these, actively support her decision-making wherever possible and ASAP. Don’t hospitalise adolescents with adults.
**Follow-up interventions**

- Intensive follow-up and ‘Green card’* improve adherence, Green Card reduces repeat DSH esp. for first time attempters
- Brief intervention & contact reduces repetition (Motto & Bostrom 2001; Carter et al, 2005; Fleischmann et al, 2008)
- Dialectical behaviour therapy for episodes in Borderline PD
- Brief Interpersonal Therapy, CBT for families?
- Research alternative approaches (safe places, peer mentors)
- (*Wallet-size card with time and date of appointment with a named mental health professional, 24 hour crisis numbers, invitation to return to ED if in crisis)
Psychiatrist Perspective

Implementation of mental health service recommendations

While et al, Lancet, Feb 2, 2012

- As more service recommendations implemented, suicide rates declined
- Those services which implemented 7 – 9 recommendations had significantly lower suicide rates than those who had only implemented 0 – 6 recommendations
Drug treatments that work?

- Antidepressant, anti-anxiety and anti-psychotic medications may be required to treat symptoms or underlying disorders, but can be misused for overdose.
- Lithium and clozapine may also be anti-suicidal.
Psychiatrist Perspective

**Safety and effectiveness of antidepressants?**

- The antidepressant story is confounded by drug company marketing and disease mongering
- Among young people SSRI antidepressants are rarely associated with suicide
- They seem more likely to be effective in moderate to severe depression and related conditions (such as anxiety and OCD disorders) but the placebo effect is also marked
Psychiatrist Perspective

Interview in ED or office

- Offer privacy in ED or office
- Let the patient tell her story and encourage this
- (learn the assessment structure thoroughly, then listen and follow the patient carefully)
- What is the existential/spiritual issue?
- Social circumstances, problems, stressors
- Events around self-harm: focus on intent, safety - access to methods, opportunity and supports
- Past history of self-harm, MH problems, coping strategies and strengths
- Mental State Exam; and Management of specific conditions (e.g. psychosis, melancholia)
Psychiatrist Perspective

Caitlin

• How does one establish a relationship in this situation? To acknowledge the fear and to repair and establish trust with MH services takes time. Caitlin must decide whether she can trust those with whom she deals, just as they must listen very carefully to her and seek her point of view.

• Is there anyone whom she trusts, who can accompany her? Who will support her, help reduce her anxiety by assisting her to care for herself, solve problems and to protect her rights?

• How to respectfully obtain a history, including treating delicate information with sensitivity – e.g. re exposure to violence and abuse.
Psychiatrist Perspective

Caitlin

- Is this a crisis (existential + grief)? What is the role of illness (persistent biological symptoms) if any? What do insecure attachment and previous trauma in relationships/MH system contribute?
- What about Caitlin’s strengths?
- Explaining very clearly what one is doing. Identifying and expressing hope, supporting Caitlin’s safety, her decision-making and her rights at each step – preferably as an outpatient, possibly in relation to engaging in therapy, maybe medication
Can we prevent suicide? Challenges for researchers

- Ethics of including suicidal persons in studies (whether in intervention or control conditions)
- Issue of low base rate and impossibility of selecting sufficient high-risk individuals for randomised controlled trials (RCTs)
Can we prevent suicide? Challenges for researchers

- Psychiatrists have questioned the value of clinical risk categorisation as a predictor of suicide (Large et al 2011)
- Is hospitalisation more harmful than useful?
- What role does medication play?
- How do doctors employ holistic clinical skills, including attentively accompanying the person through the crisis?
Ought we prevent suicide? Antecedent moral considerations

- This is not just a question that arises in the case of terminal illness or unpalliated profound disability
- Young single father with 4 year old son, early 30s, mental health worker
- Died by suicide in 2012.
- Past overdose known only to former supervisor, otherwise without warning
- His colleagues deeply shocked, distressed, gave testimonies at the funeral about the great quality of his work, yet affirmed his right to make his own choice about this and not theirs to interfere
- Arguments for and against this view??
Ought we prevent suicide? Antecedent moral considerations

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Can we prevent suicide? Dearth of empirical evidence

- The state of the evidence about this, given the constraints
Routine A & E Assessment works

- Hickey et al, 2001
  - Those who were not assessed psychiatrically in A and E in Oxford had greater repetition of deliberate self-harm
- Kapur et al, 2002
  - Similar results to Hickey et al.
  - Calculated that only need to assess 12 patients to prevent one repetition of self-poisoning
Inadequate Treatment for Major Depression Both Before and After Attempted Suicide

- Underlying MH and social problems that are frequently detected in relation to suicide attempts or self-harm need clinical attention but predictors are based on aggregate data.

- “It seems that few suicide attempters with major depression receive adequate treatment for depression before the suicide attempt and that, despite their well-known high risk for suicide, the treatment situation is not necessarily any better after the attempt.”

  (Suominen et al., Am J Psychiatry 1998, 155:1778)
What about hospitalisation?

- Ethical problems with undertaking RCTs of this
- Increasing recent attention to coercion in psychiatry and Bergk et al’s Coercion Experience Scale as a way of quantifying these experiences
- Still a surprisingly significant dearth of research on traumatic effects of psychiatric hospitalisation (with possible exception of women who have prior histories of assault)
- Legislation may not distinguish admission, specific treatment(s), seclusion and restraint
- NB: Aeschi and other recent qualitative studies of experiences of suicidal people in services
Psychiatric hospitalisation and SP

Some positive evidence:

- Agerbo (2009), Danish population-based cohort study of all first-ever psychiatric patients (16-65 yrs) admitted 1981-1998, with longitudinal data on income, education, employment, marriage. (96369 patients, 256619 admissions, 2727 suicides)

- Hospital readmission prevented suicide and suicide risk was reduced in patients who stayed in hospital longer than their previous admission and for longer than others with similar disorders
Psychiatric hospitalisation and SP

• Hunt et al (2009): 250 UK patients dying by suicide within 3 months of discharge; and 250 control psychiatric patients
• Patients who were detained for compulsory treatment at last admission, and those who were subject to enhanced levels of aftercare (care co-ordinator supervision and multidisciplinary case reviews), were less likely to die by suicide
Dangers of SSRIs in youth?

- In FDA analyses in 2003, more than 4400 children and adolescents showed a higher incidence of suicidality (suicidal thoughts, attempts) in those receiving antidepressants, mostly SSRIs, compared with placebo (4% vs. 2%).
- BUT Epidemiological data links higher SSRI use with lower suicide rates across many countries and over time (this is association, not causation)
- In moderate-severe depression, benefits for fluoxetine and possibly other SSRIs apparently outweigh risks.
- SSRIs are found in only 1.7% of child and adolescent suicide victims (Dudley et al, 2010)
Management Outline (RANZCP 2004) = expert opinion + evidence-based

- Establish rapport/therapeutic alliance
- Assess risk to self and others
- Psychosocial assessment (+ collaborative Hx)
- Conduct and record MSE
- Identify, initiate treatment for clear mental disorders
- Mobilise supports & coordinate treatment with patient, family and other health services
- Ensure safety at care transitions and discharge
- Address access to means (e.g. amount, lethality of drugs, firearms)
- Enhance resilience and adaptive coping
Suicidal Intent 1

- What led up to the suicidal behaviour?
- How much planning has there been?
- Was the behaviour pre-meditated or impulsive?
- What were the person’s feelings about living and dying?
- What was the knowledge and expectation of the person about the potential lethality of their actions?
- Have there been any acts in anticipation of death, such as making a will or saying goodbye to others?
Suicidal Intent 2

- Has suicidal intent been conveyed to others?
- Is the suicidal behaviour aimed at influencing others in the environment?
- Has the person acted to gain help during or after the attempt?
- Have precautions been taken against discovery or intervention during the attempt?
- Has the behaviour occurred in isolated circumstances, or where others could intervene?
Ensuring continuity of care

- Clinical pathways (Accessible and available services, transition management guided by stakeholder collaboration and structural linkages)
- Comprehensive services (including if required, housing, education, support, vocational assistance etc)
- Timely, accurate and ongoing communication to all parties
- Individualised care
- Contract at least 3 sessions
Aftercare

• Definite, prompt follow-up appointment time at time of initial assessment (e.g. DSH clinics)
• Written communication to aftercare agency summarising circumstances of presentation, results of assessment and treatment
• Reminder phone calls or home visit if patient defaults
Potentially preventable suicides

- UK National Confidential Inquiry (1999) and Burgess et al (2000) in Australia considered 22% and 20% respectively of suicides preventable but for:
  - Poor assessment and treatment
  - Poor staff-patient and staff-staff communication and relationships
  - Inadequate supervision
  - Lack of continuity of care
Thank you for your participation

- Please ensure you complete the *exit survey* before you log out (it will appear on your screen after the session closes). Certificates of attendance for this webinar will be issued in 4-5 weeks.
- Each participant will be sent a link to online resources associated with this webinar within 1-2 days.
- For more information about MHPN networks and online activities in 2013 visit [www.mhpn.org.au](http://www.mhpn.org.au)
Are you interested in leading a face-to-face network in your local area with a focus on Suicide Prevention?

MHPN can support you to do so.

Please fill out the Expression of interest that you’ll receive as a link in the webinar follow up email. MHPN will follow up with you directly.
Thank you for your contribution and participation