

Preventing suicide: How to provide a suicide- focused intervention

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What we'll cover

- ▶ Mental health and suicide
- ▶ Risk assessment, risk and protective factors.
- ▶ Aims and principles of a suicide focussed intervention
- ▶ Two skills: Safety planning and reducing means



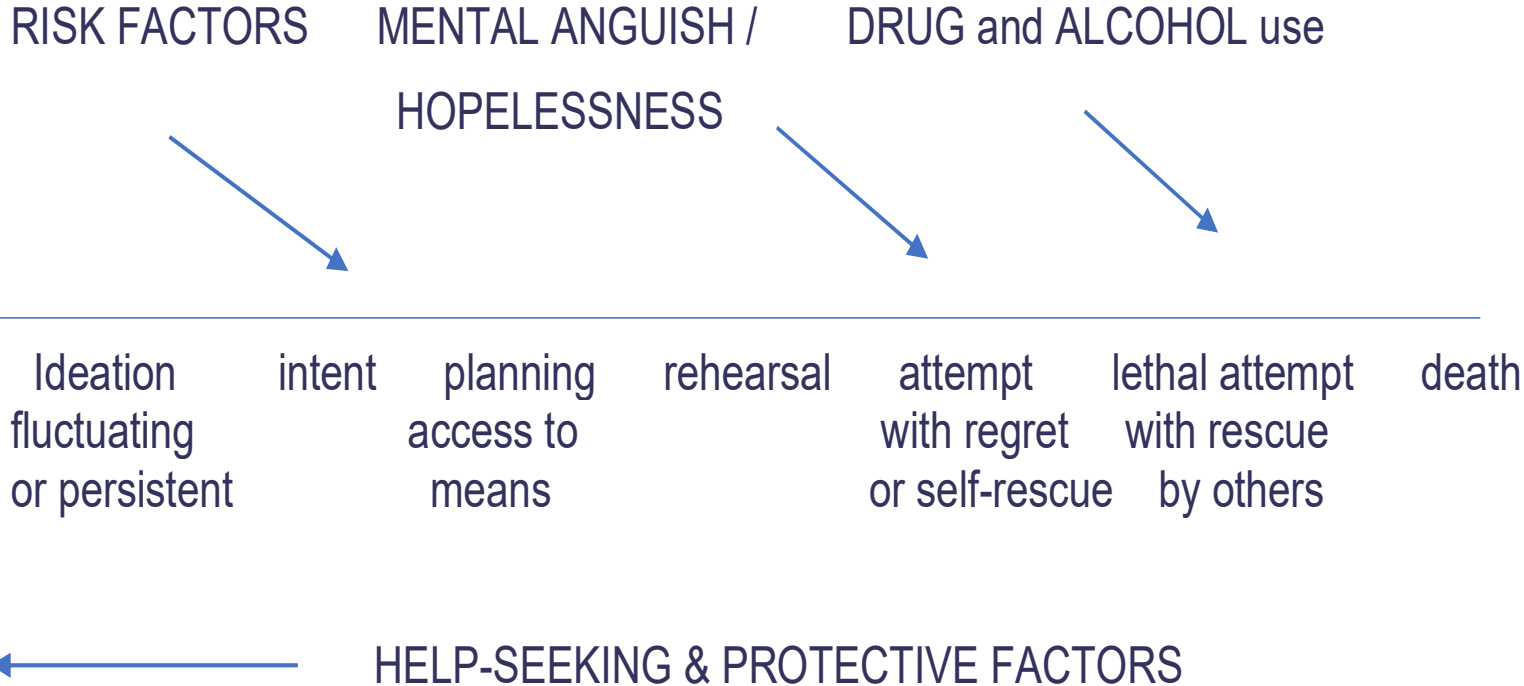
Common myths include

Myth: Talking about suicidal thoughts and feelings could make you more likely to act on them.

Evidence suggests that asking people about suicide does not increase their risk and may be beneficial (Gould et al 2005; Dazzi et al 2014; Blades et al 2018).



FROM THOUGHT to ACTION



When assessing: be specific regarding current and historic risks; date potential lethality



WHO study. Nock et al 2008

- ▶ studied 84,850 people from the general population in 28 countries to identify any association between suicidal thoughts, plans and suicidal behaviour.
- ▶ 29% of people with suicidal thoughts went on to make a suicide attempt, 60% of whom did so within a year of onset of suicidal thoughts.
- ▶ Individuals with a suicide plan had a 56% probability of making a 'suicide attempt' whilst those without a plan had a 15.4% probability of a 'suicide attempt'.



Mental health and suicide

- ▶ Clinical depression, self-harm and substance misuse are significant risk factors for suicide. EUPD is the diagnosis with the highest risk of suicide followed by depression, bipolar disorder, opioid use, and schizophrenia (Chesney et al 2014).
- ▶ Patients most at risk are those with a combination of risk factors, such as people with high-risk mental health problems (major depression, EUPD and /or substance misuse) who then experience loss (Cheng et al 2000).
- ▶ More than half of suicides do not merit a psychiatric diagnosis (Stone et al 2018) & most people with mental disorders do not attempt suicide (O'Connor & Nock 2014).
- ▶ Suicidal ideation and risk is also associated with social factors such as poverty; homelessness and unemployment as well as specific psychological problems such as emotion



Traditional approach to suicide prevention in MH services

- ▶ The traditional approach to suicide prevention in mental health services is to diagnose and treat mental disorders.
- ▶ However, there is extensive evidence that targeting and treating mental disorders has little impact on suicidal risk (Braun et al 2016; Cuijpers et al 2013; Zalsman et al 2016, Jakobsen et al 2017).
- ▶ (Individuals with suicidality present with a variety of needs that are not exclusively mental-health-based, including social, community, relationship and individual risk factors Brent 2016).



Levels of care needed

most restrictive / highest cost



- Inpatient care
- Day treatment
- Crisis care / Home treatment
- Intensive Clinical Management
- Outpatient care and medication/ Evidence-based therapies & **SFIs**
- Samaritans and other help-lines
- Third sector support; engagement with people with lived experience to reduce risk factors/ increase social support

Least restrictive / lowest cost

adapted f



Risk assessment

The goal of risk assessment is not to predict the likelihood of suicide but to assess the patient, their needs and use this information to plan for safety and treatment.

Hawton 2017 and Jobes (2018) recommend we use a process of progressive questioning to gather relevant information to inform a risk formulation that leads to an individualized intervention.

This includes

Assess risk factors (chronic or acute) e.g.

- ▶ Previous self-harm or suicide attempts.
- ▶ Access to lethal methods.

Protective factors (buffers) e.g.

- ▶ Connectedness
- ▶ Perceived social support Future planning
- ▶ Engagement with children; family & services



Help-seeking

- ▶ 38–50% of people who end their life, tell someone close to them before (Mays 2004, Shen et al 2006).

Most have had contact with a healthcare provider within days or weeks of their suicide.

- ▶ Around half of people who have died by suicide speak to a GP in the previous month, though not necessarily disclosing their suicidal thoughts (Harwitz & Ravizza 2000; Luoma et al 2002; Stene-Larsen & Reneflot 2019). Of those appointments, 50% were for psychological or psychosocial reasons (Isometsa et al 1995). On average, *45% of suicide victims have had contact with primary care providers within 1 month of suicide.*
- ▶ However *less than one in 3 people who end their life by suicide had contact with a mental health service previous month* (Stene-Larsen & Reneflot 2019) in the year before their death (Appleby et al 199



Intervention



When to signpost or contact a GP, ED; phone 111 (NHS) or the police (999).

Risk level of suicide	General public / other agencies	Mental health professional
Not imminent	GP	Address directly with patient; discussion in supervision and MDT and review risk regularly
Urgent / out-of-hours	111 (free and open 24/7)	Crisis service*
Imminent esp. if in public place; others at risk or person non-compliant with their own safety	999 Police	999 Police
Acted on and in need of medical attention	Ensure the individual goes to ED or call 999 Ambulance	Ensure the individual goes to ED or call 999 Ambulance

*Most crisis teams will accept referrals from GPs and primary mental health services; internally from EDs. They would aim to see a patient face to face within 4 hours and ideally would be trying to c



Management of high-risk individuals

If high level of risk is identified,

- ▶ Consider frequency of appointments
- ▶ Ensure safety with 24-hour support through the crisis team of the local mental health service and possible admission.
- ▶ Consider grounds for assessment and detention under the Mental Health Act if the person refuses.



Safety and treatment planning principles

Reduce suicide risk factors	To reduce the severity of established suicide risk factors (depression, hopelessness, suicidal ideation, etc.)
Enhance effective coping	To enhance effective coping, emotion regulation, and problem-solving skills, such that suicide is no longer viewed as the only solution to one's life problems
Minimize social isolation	To help the patient gradually establish a new social support network or more adaptively use an existing social support network
Improve treatment adherence	To increase adherence to medical care, including mental health and treatment for substance-related disorders
Plan for safety	To prepare patients, family members, and friends to implement emergency safety plan procedures when urges high



Psychological interventions for reducing suicide risk (SFIs)

There is increasing evidence of psychological interventions reducing suicide risk

- ▶ Collaborative Assessment and Management of Suicidality (CAMS, Jobes 2006 & 2016)
- ▶ CBT: Tarrier et al 2008, Mewton and Andrews 2016, Leavey & Hawkins 2017, Gotzsche & Gotzsche 2017, D'Anci et al 2019
- ▶ Other suicide-focussed therapies – Winter et al 2013, Erlangsen et al 2015, Calati and Courtet 2016, Meerwijk et al 2016, Mendez-Bustos et al 2019

See Bell 2021 for further information incl interventions for A&E



Two broad approaches to SFIs

The earliest models are manualised and usually have a specified number of sessions.

However, they have major disadvantages. When people are suicidal they may not take well to a preordained order of session topics. It is a common experience in secondary care services for these manualised approaches not to suit clients who need careful pacing and relationship-building within an evidence-based format. As engagement is such a high priority, I therefore favour a more flexible approach such as CAMS or the one proposed in part 111 of my book.



Aims of an SFI

to

- ▶ engage patients who are struggling with persistent suicidal intent
- ▶ work alongside them as they make changes with a view to reducing suicide risk

It is a collaborative rather than a formulaic, 'off the peg' or instructional approach which we can get pulled into doing when under time pressure to agree a risk plan

This process could take 2–12 sessions, depending on the willingness, motivation and competence of the patient and your availability.



A suicide–focussed intervention is based on:

- ▶ agreeing a clear focus on suicide risk and risk reduction
- ▶ creating a therapeutic relationship with the client
- ▶ an individualised (personal) formulation of 2 key factors driving and maintaining suicidal intent
- ▶ supporting the person to increase safety and reduce suicidality
- ▶ identifying and working with ambivalence
- ▶ identifying and addressing obstacles to change
- ▶ shaping and pacing behavioral change
- ▶ modelling flexibility and willingness e.g. see family members if that could be helpful.



throughout, we want to

- ▶ Increase connectedness/ belongingness
- ▶ Work collaboratively – suicide is partly about trying to get some control over feelings or events which the person feels are out of their control. Offer choice
- ▶ Build skills – suicide is a solution when you don't know what else to do
- ▶ Have a personalised approach based on what we know and what the person tells us – avoid off the peg, generalised suggestions.



Ten suicide intervention skills

1. Safety planning: Promoting adherence to the plan; trouble shooting and rehearsing a safety plan
2. Reducing means and 'shaping' appropriate help-seeking
3. Functional analysis of last suicide attempt. Identifying – thoughts emotions physical sensations urges and actions
4. Using metaphors and similes
5. Exploring ambivalence: reasons for living and reasons for dying and Motivational Interviewing skills
6. Problem-solving – basic steps
7. Working with goals and values: building positive experiences and a life worth living.
8. How to make and use a *hope box*
9. Mindfulness skills: Noticing our mind. We are not our thoughts. Everything is subject to change. Balancing acceptance and change skills
10. Distress tolerance skills *STOP and TIP, surf, improving the moment*



The basic components of safety planning (Skill 1)

Include

- ▶ recognising warning signs for a suicidal crisis;
- ▶ using coping strategies;
- ▶ utilising social contacts and social settings as a means of distraction from suicidal thoughts;
- ▶ utilising family members or friends to help resolve the crisis;
- ▶ contacting mental health professionals or agencies; and
- ▶ restricting access to lethal means.



Creating a safety plan

Adapted from Stanley and Brown (2012)

Element of plan	Sample questions
Warning signs and personal triggers	<ul style="list-style-type: none">• Are there any specific situations or people that you find stressful or triggering, or that contribute to your suicidal thoughts?• How will you know when your safety plan should be used?• What are some of the difficult thoughts, feelings or behaviours that you experience leading up to a crisis?
Reducing access to means ('making things safer for you')	<ul style="list-style-type: none">• What things do you have access to that are likely to be used in a suicide attempt?• How can we develop a plan to limit your access to these things to help you stay safe?
Identifying Reasons For Living	<ul style="list-style-type: none">• What's the best thing about your life?• What's the most important thing in your life?• Is there anything in your future you are looking forward to?
Internal coping strategies	<ul style="list-style-type: none">• What can you do on your own if you have suicidal thoughts in the future, to avoid acting on those thoughts?• What has helped you in the past cope with suicidal thoughts?
Social contact	<ul style="list-style-type: none">• Who helps you to feel good when you spend time with them?• Where can you go and be around other people in a safe environment?
Trusted contacts for assisting with a crisis	<ul style="list-style-type: none">• Among your friends and family, who do you feel you could talk to about your suicidal thoughts?• Who do you feel you could contact to support you during a suicidal crisis?• Which services or professionals can you turn to for support?



Rehearsing and trouble-shooting the safety plan

- ▶ Address obstacles. Troubleshooting what stops people seeking help; connecting to others etc.(consider hot cross bun and core beliefs).
- ▶ Imaginal rehearsal. Ask the patient again to take you through the sequence of events leading to the most recent episode of suicide ideation or suicidal self-directed violence. This time, direct them to use the skills learned in therapy to respond cognitively, affectively, and behaviourally to take positive steps toward staying alive. If the patient is moving too fast or neglecting important points, stop and ask about alternative ways of thinking, feeling, and behaving. Use as much time as needed until the patient is able to demonstrate use of at least several strategies to prevent suicidal

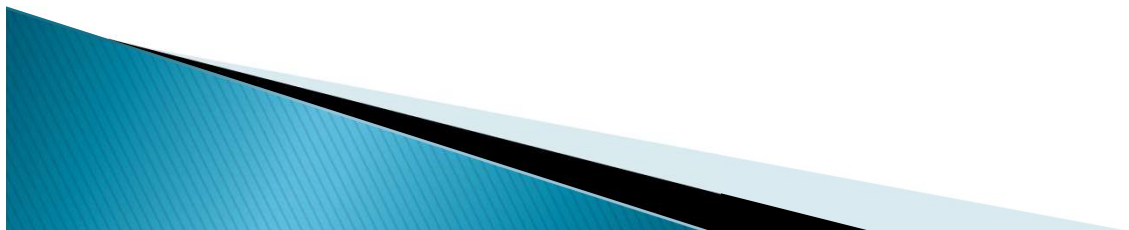


Skill 2: Reducing the potential for use of lethal means

Where suicidality is expressed, discuss access to means and strategies to reduce risk.

Service users should be encouraged to take responsibility for disposing of or handing in means that they are in possession of and are thinking of using to self-harm.

It is important to explore ambivalence here; the articulation of suicidality is evidence of ambivalence and provides opportunities to look for reasons for living etc.



Shaping

When shaping behaviour, we reinforce *gradual approximations* of a targeted, desired or skilful behaviour. It is important to pace it in realistic steps and know where to pitch our expectations.

Shaping comes with

- ▶ Carefully paced goal setting and monitoring how this goes
- ▶ Cheerleading and positively reinforcing steps taken and achieved
- ▶ Rehearsing skills in session (in imagination or role play)
- ▶ Generalising this to natural environments through 'homework' tasks.



Ending sessions

- ▶ has the person's risk reduced?
- ▶ fade contact
- ▶ revise safety plan as needed before discharge
- ▶ consider telephone booster sessions
- ▶ outstanding needs & signposting



APPS

To support safety planning you may want to advise service users with android or iPhone to download the Stay Alive suicide prevention App which has safety planning pages which include reasons for living, life box, how to stay safe right now, breathing and grounding techniques etc.

http://prevent-suicide.org.uk/stay_alive_suicide_prevention_mobile_phone_application.html

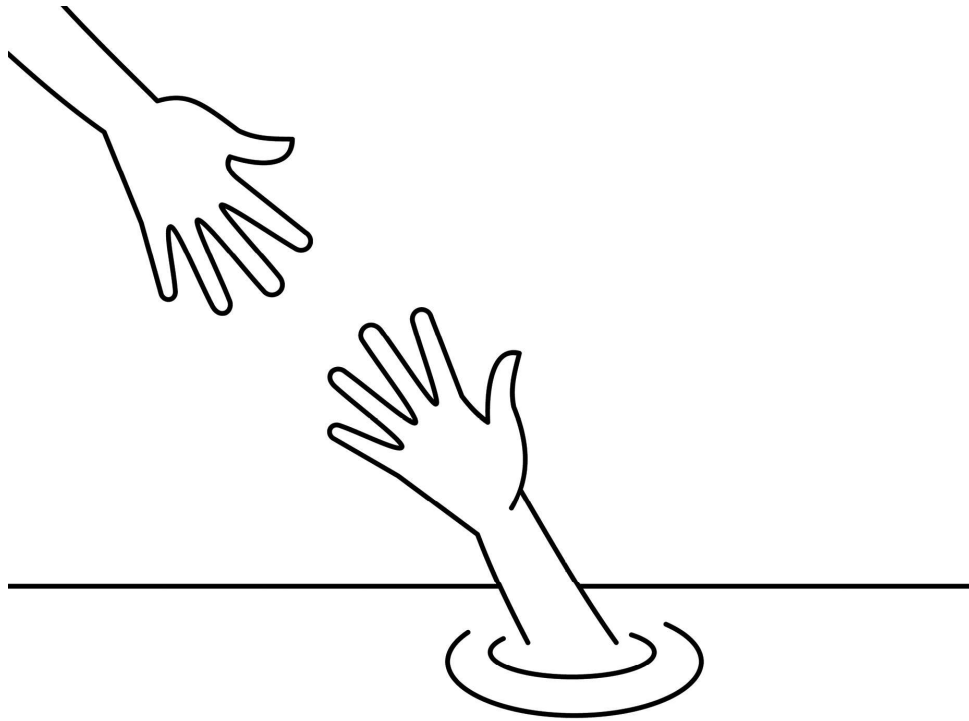
For self-harm you can advise the DistrACT app:

<http://www.expertselfcare.com/health-apps/distract/>

The service user should keep a copy, and where possible the carer, and a copy should be stored on their notes.

Hope apps. Although the hope box is a helpful tool, it isn't always close at hand. To address these limitations, the [Virtual Hope Box](#), a free smart phone application (Apple, Android) has been developed which allows someone to keep a virtual collection of their reasons for living close by at all times. The Virtual Hope Box has the same types of items (although in digital form) as the traditional (photos, videos, music, messages from loved ones), plus coping, relaxation, distraction, and positive thinking.





HELPING PEOPLE OVERCOME SUICIDAL THOUGHTS, URGES AND BEHAVIOUR

SUICIDE-FOCUSED INTERVENTION SKILLS FOR
HEALTH AND SOCIAL CARE PROFESSIONALS

LORRAINE BELL



Helping People Overcome Suicidal Thoughts, Urges and Behaviour draws together practical and effective approaches to help individuals at risk of suicide.

The book provides a framework and outlines skills for anyone working with adults who present with suicidal thoughts or intent. Part 1 introduces a basic understanding of our knowledge about suicide and UK policy; Part 2 outlines the research into the treatment of suicidality and the general principles for working in the safest possible way. Part 3 outlines ten key psychological skills in the context of evidence-based best practice. The book also discusses the role of health and social care professionals in the prevention of suicide in the context of Covid-19. The book will be a valuable addition to the resources of professionals including psychotherapists, nurses, social workers, occupational therapists, prison and probation officers, drug and alcohol practitioners and support social care context.

