RISK

EMOTIONS
THE RISKY BEHAVIOURS THAT GO WITH THEM
&WHAT WE NEED TO DO ABOUT THEM

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OUR ROLE

Assessment

Identify and describe factors that expose our clients or others to:

- Danger
- Loss
- Injury
- Other adverse circumstances

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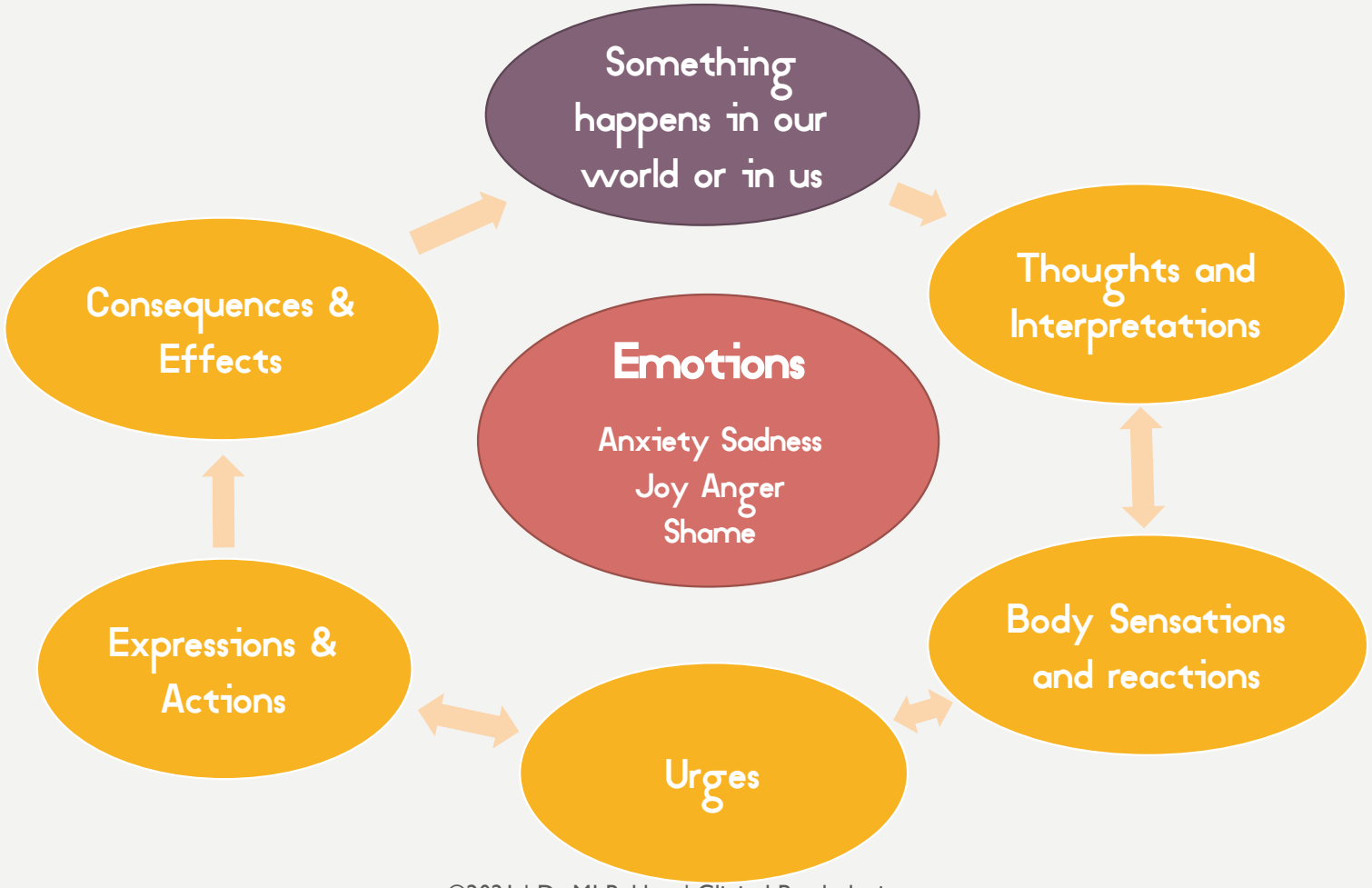
WHAT ARE EMOTIONS ANYWAY?



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WHY DO WE HAVE THEM?

Communicate

Ourselves

* Inform Actions
* Keep us safe
* Motivate us

Others

* Encourage support
* Warn
* Push away

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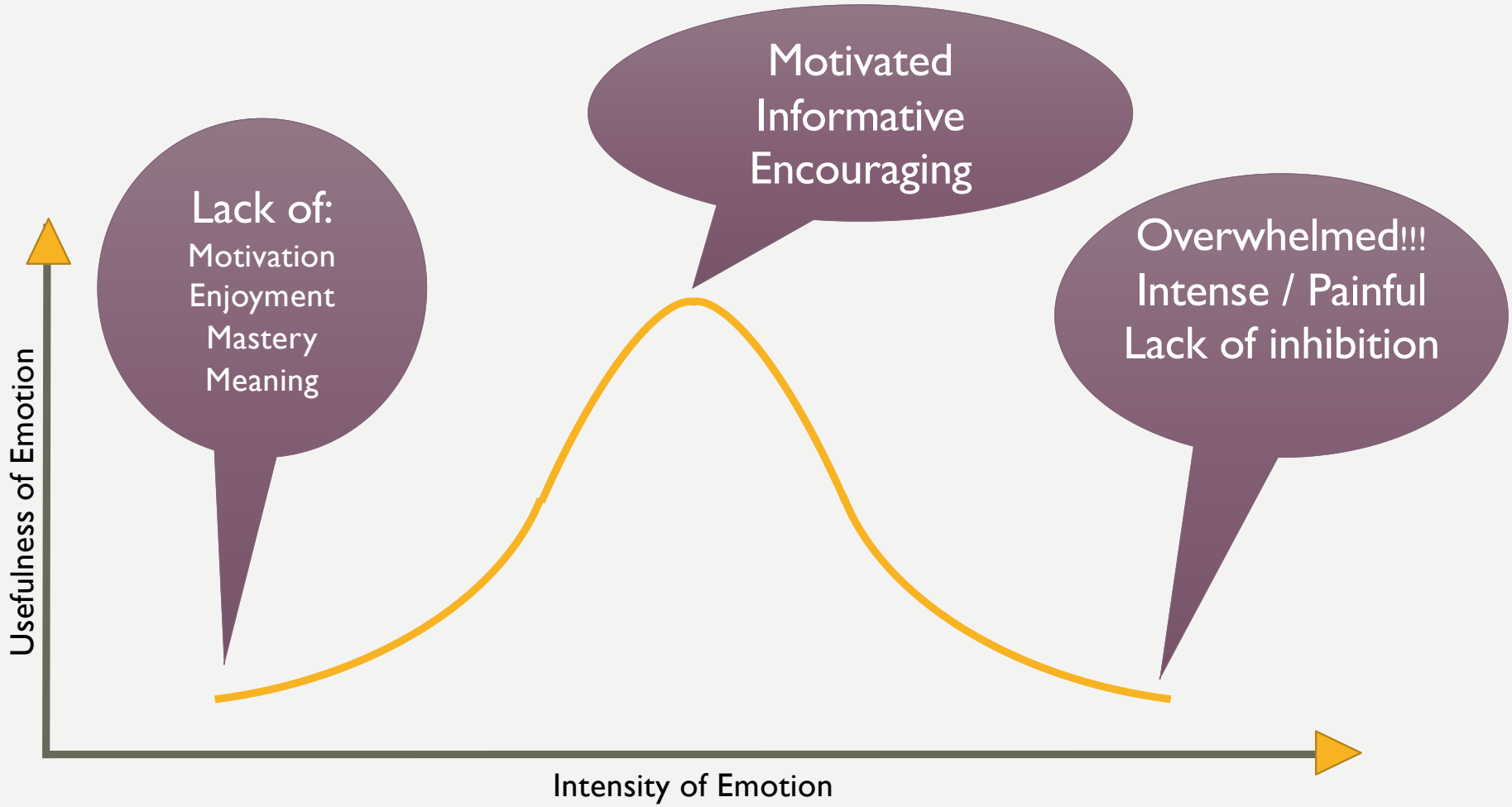
WHEN ARE THEY UNHELPFUL THEN?



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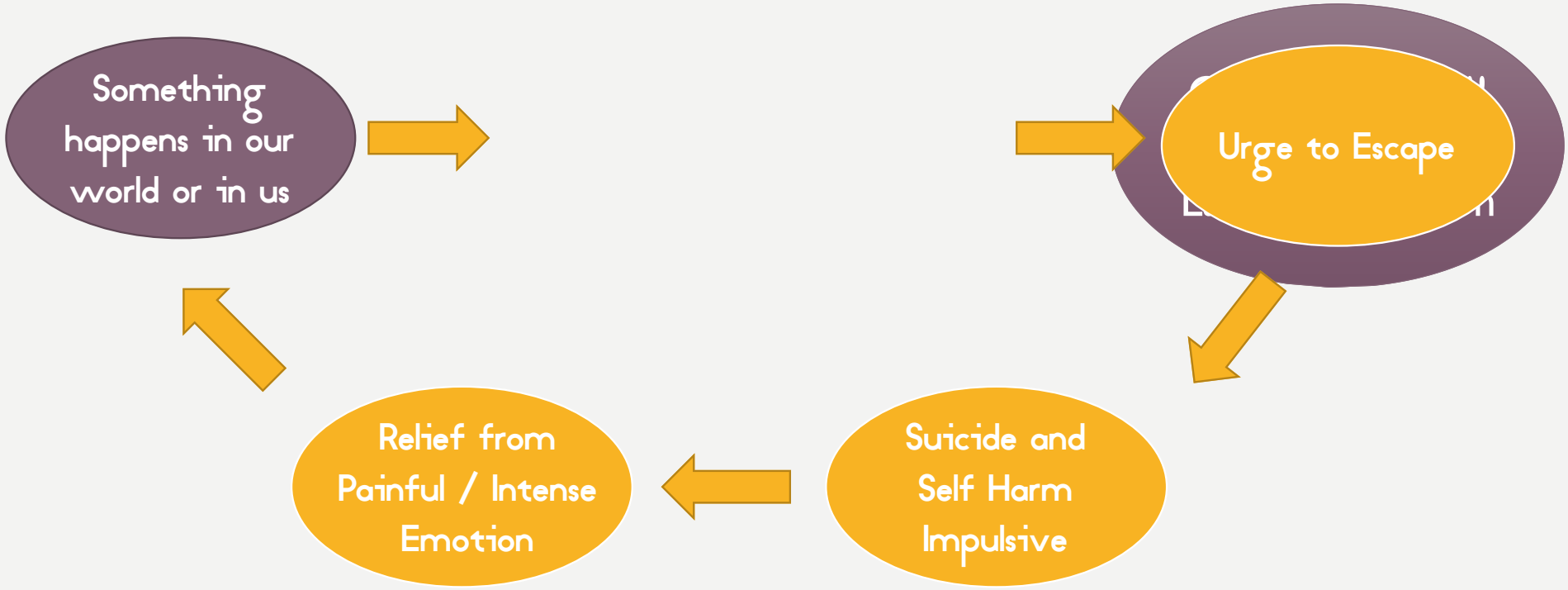
PROBLEM SOLVING INTENSE EMOTIONS



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WHY SUICIDE OR SELF HARM?

Internal

- Regulate Emotions
- Self-punishment
- Distraction

External

- To pull people in or push them away
- To get needs met

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SO WHAT DO WE KNOW ABOUT SUICIDE IN NZ?

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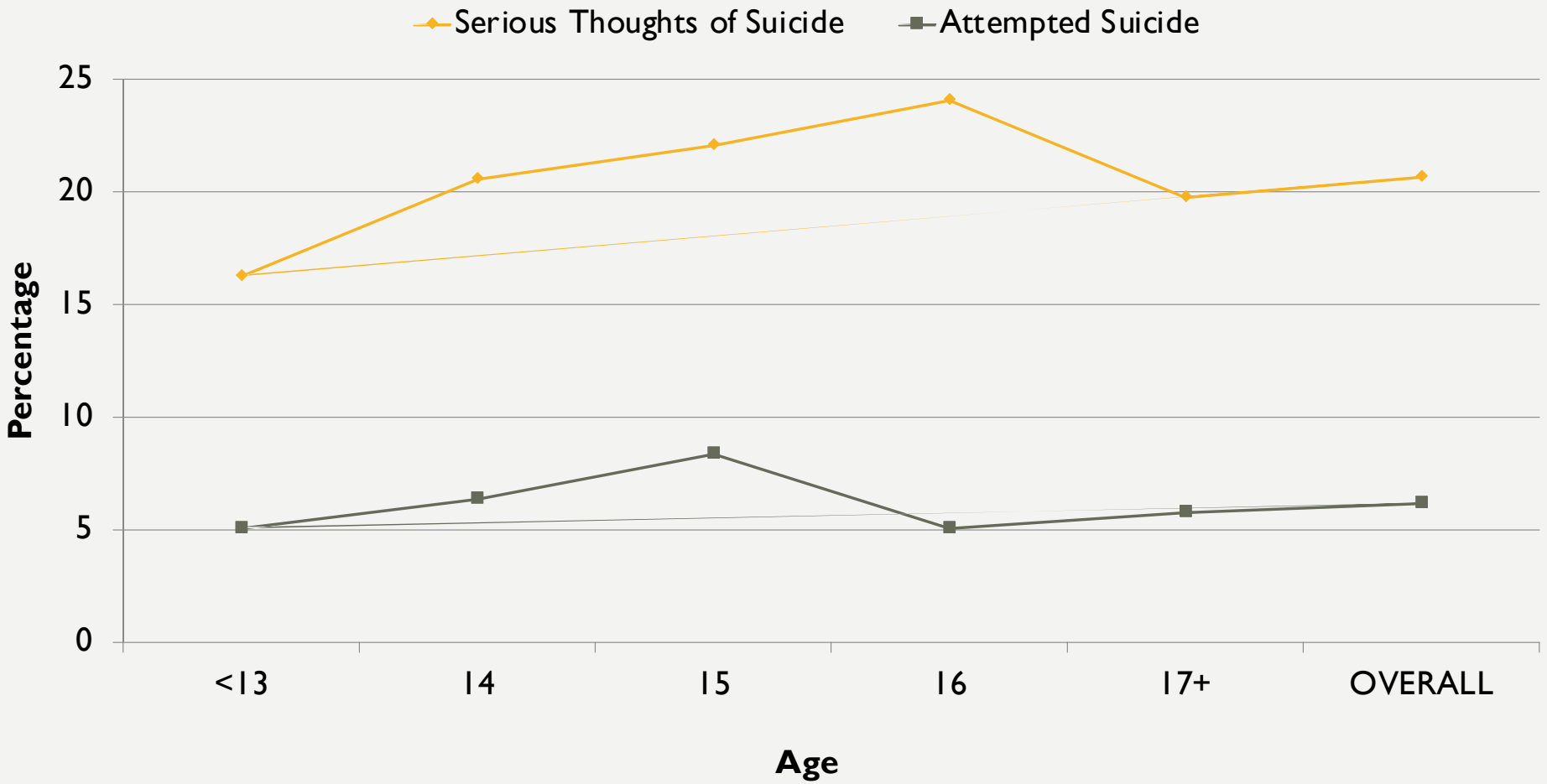
YOUTH19 NZ SURVEY



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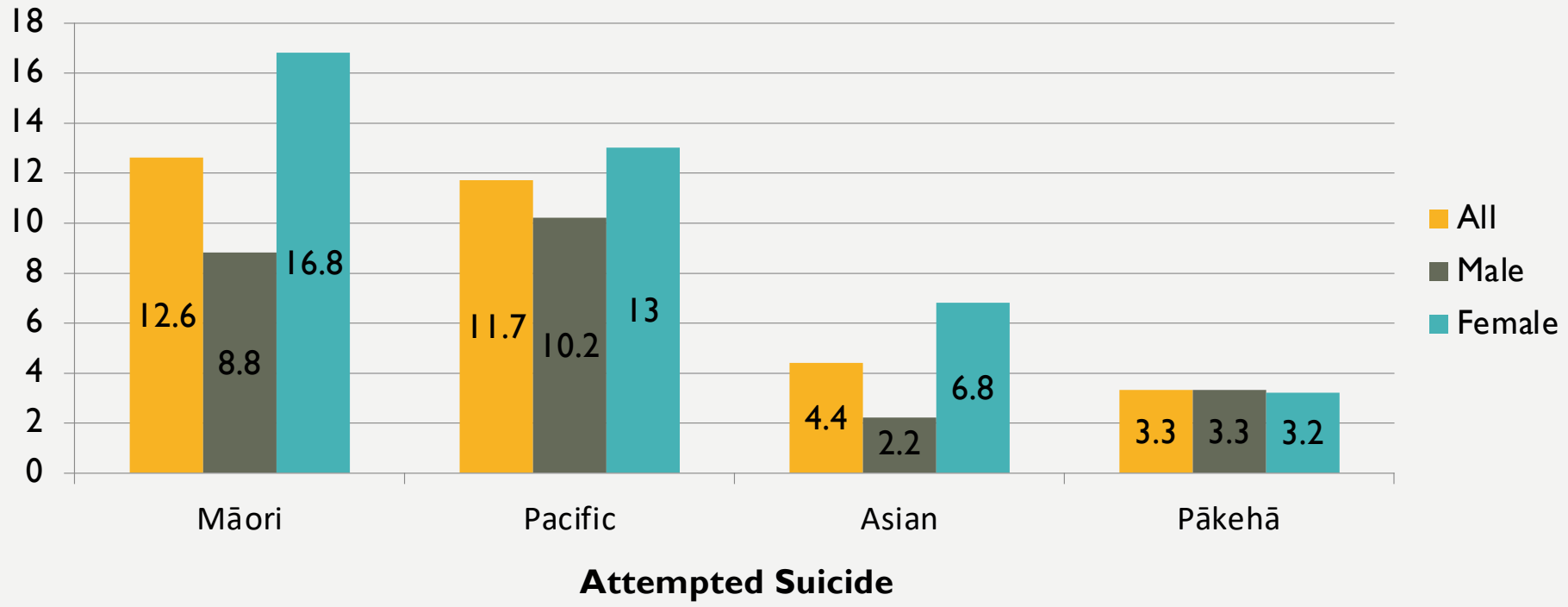
YOUTH19 NZ SURVEY



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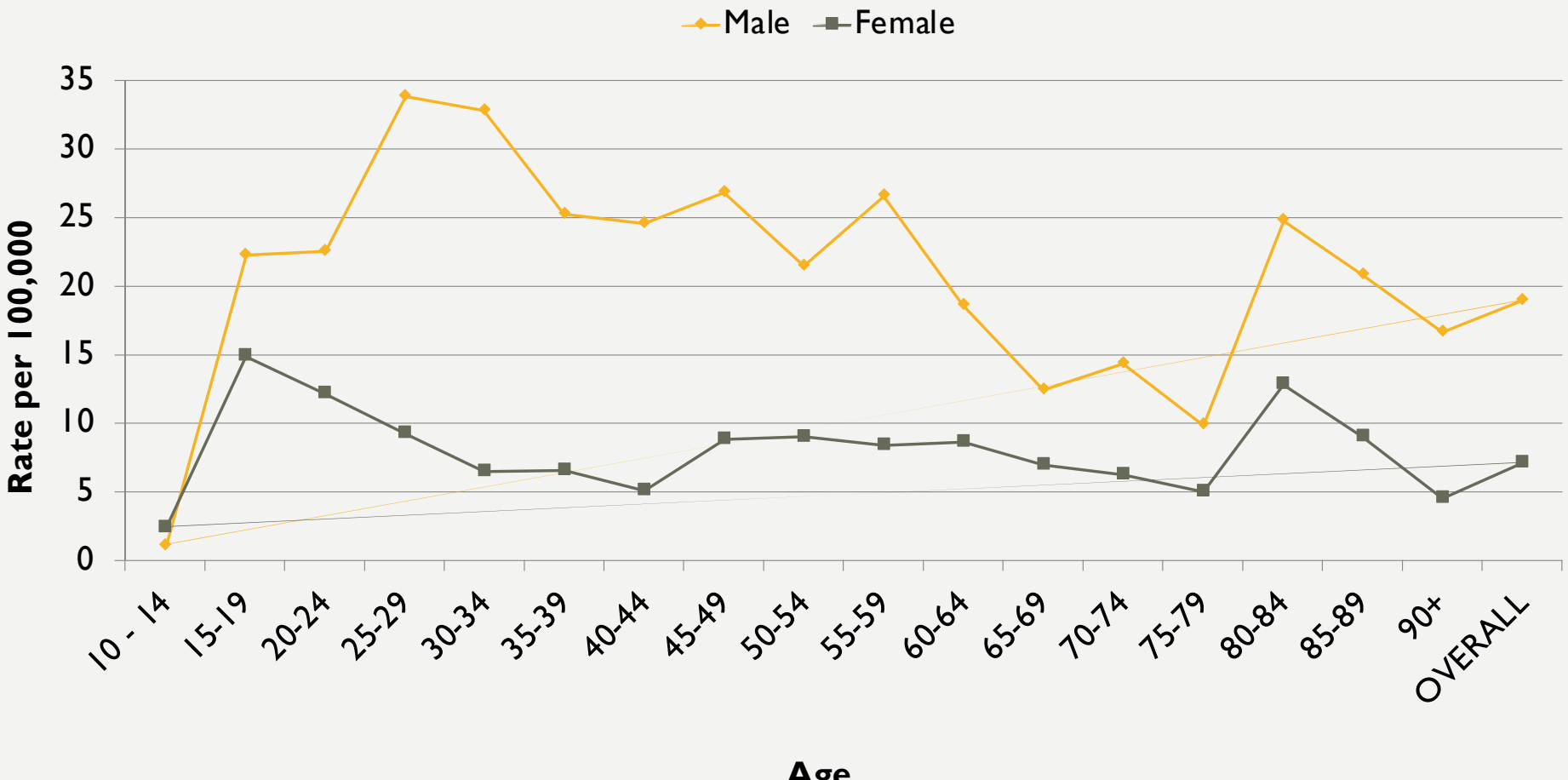
CORONERS REPORT 2019/2020



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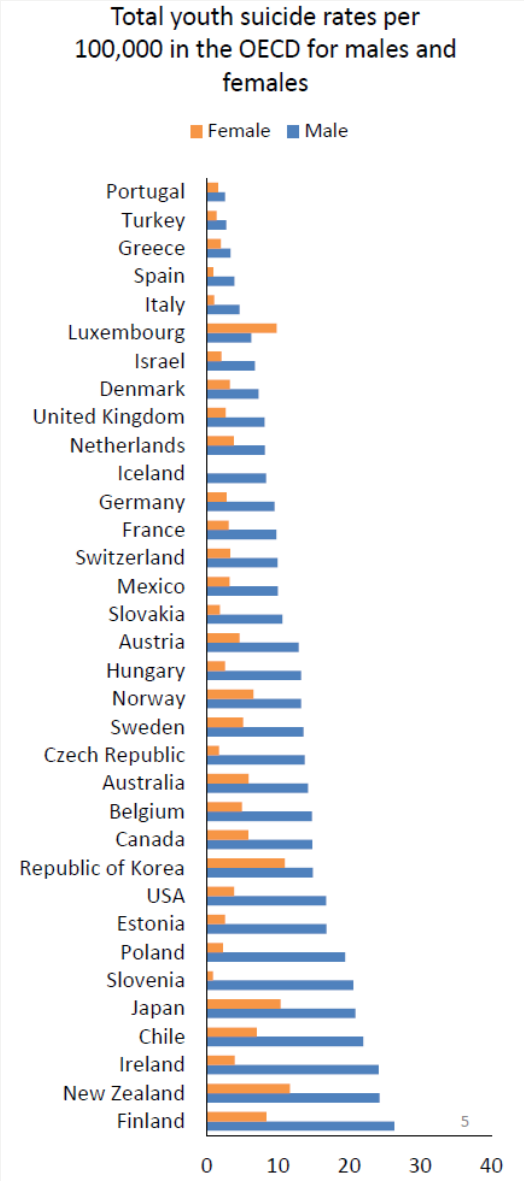

DEATH BY SUICIDE IN NZ

- **2019-2020,** 654 people died by suicide, 471 men, 183 women, 59 people <19yo
- **2.5 times more men** died by suicide than women
- **Youth (15–24 years) have higher suicide rates** than other age groups
- **Māori (in particular youth)** have **higher suicide rates** than youth from other ethnic groups.
- **New Zealand's female youth suicide rate** was the **highest**.
- **New Zealand's male youth suicide rate** was the **third highest**
- On average **40%** of people who died by suicide **accessed mental health services** in the year before they died.
- Around **30%** of people who died by suicide **were hospitalised for self harm** in the year before they died.
- More **women** who died by suicide **were hospitalised for self harm** before they died.
- **Hanging, strangulation, and suffocation** are the **most common.**
- **More females use poisoning** as a method than males.
- **More males use firearms and explosives** as a method than females.

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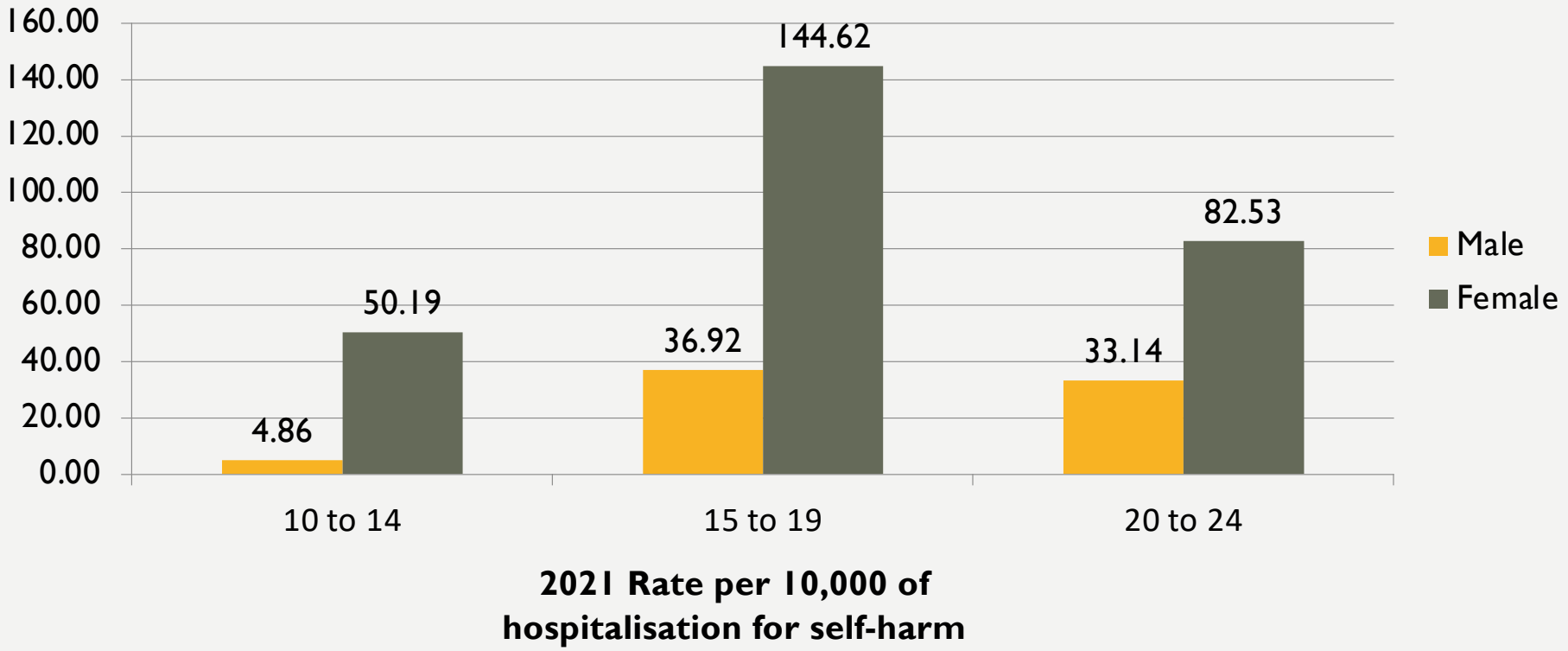
NZ DHB DATA ON SELF HARM HOSPITALISATION



2021 Rate per 10,000 of hospitalisation for self-harm

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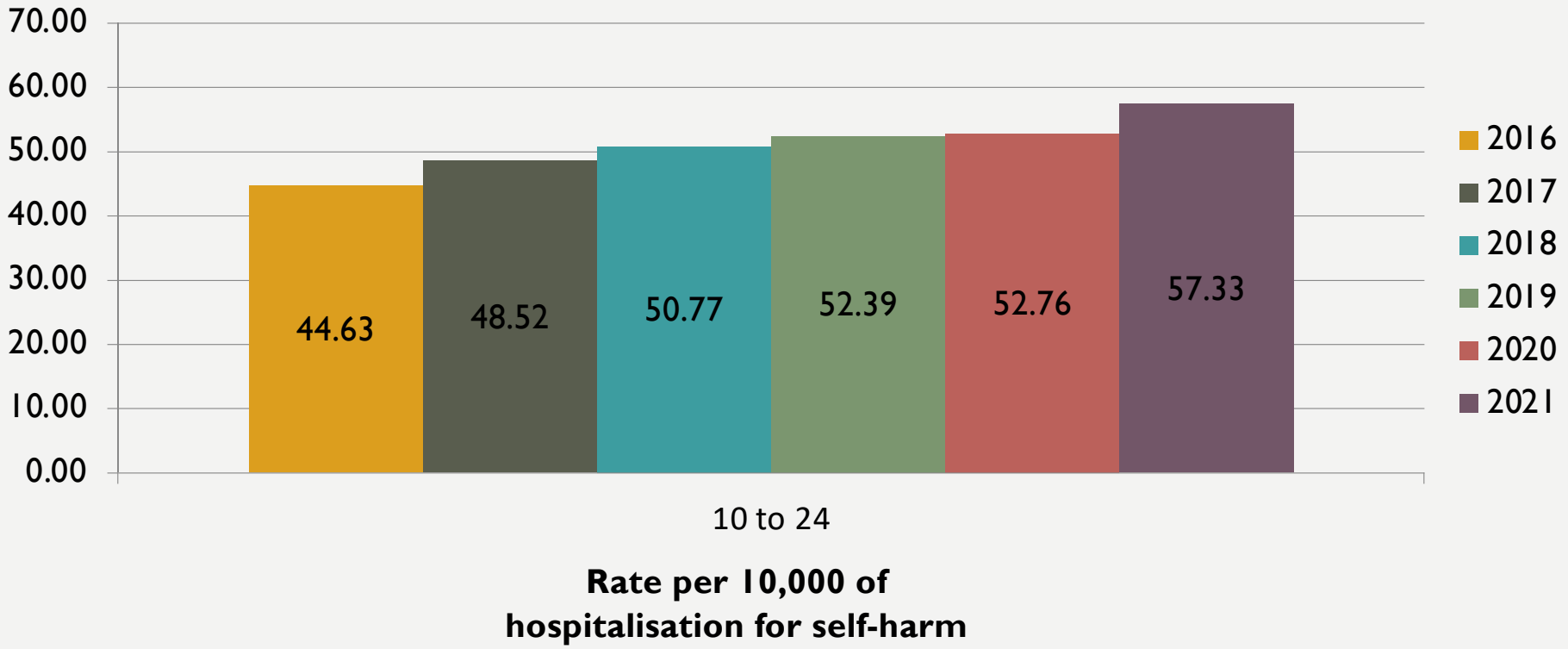
NZ DHB DATA ON SELF HARM HOSPITALISATION



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UNDERSTANDING RISK A BIT MORE & ASSESSMENT

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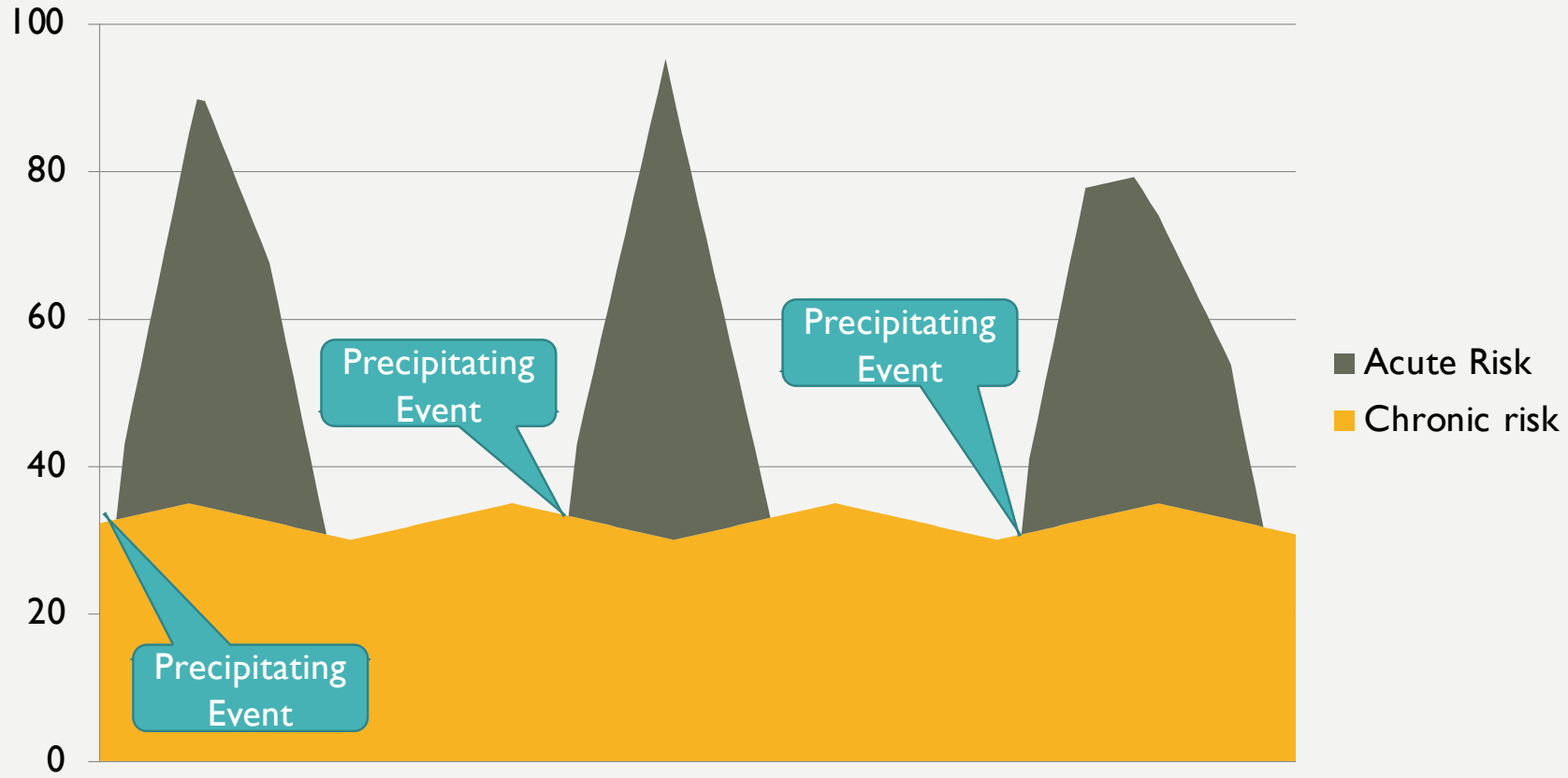
TYPES OF SUICIDE RISK



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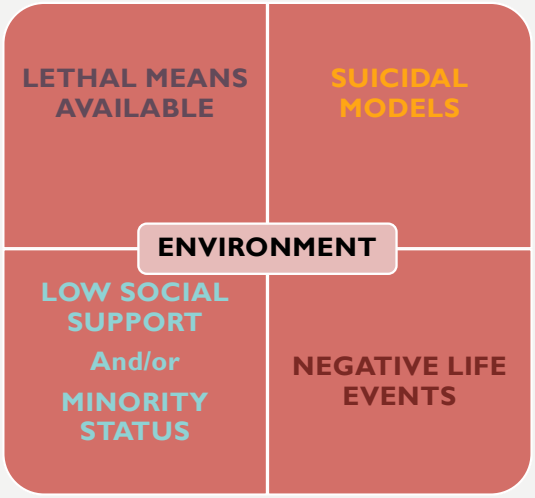
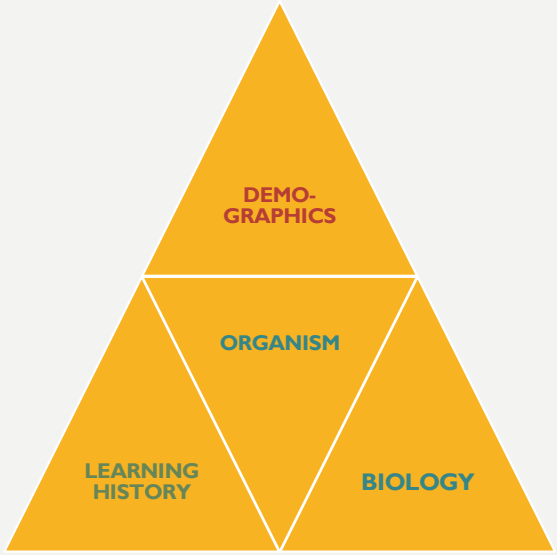
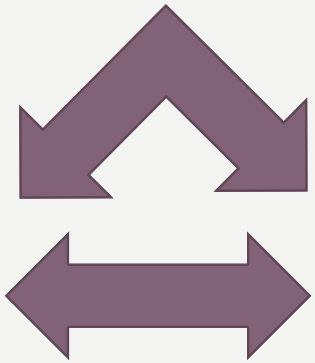
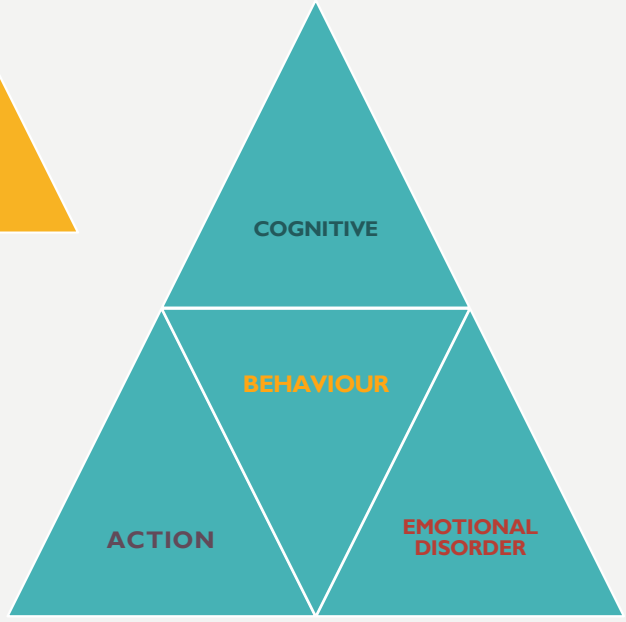
LONG TERM SUICIDE RISK









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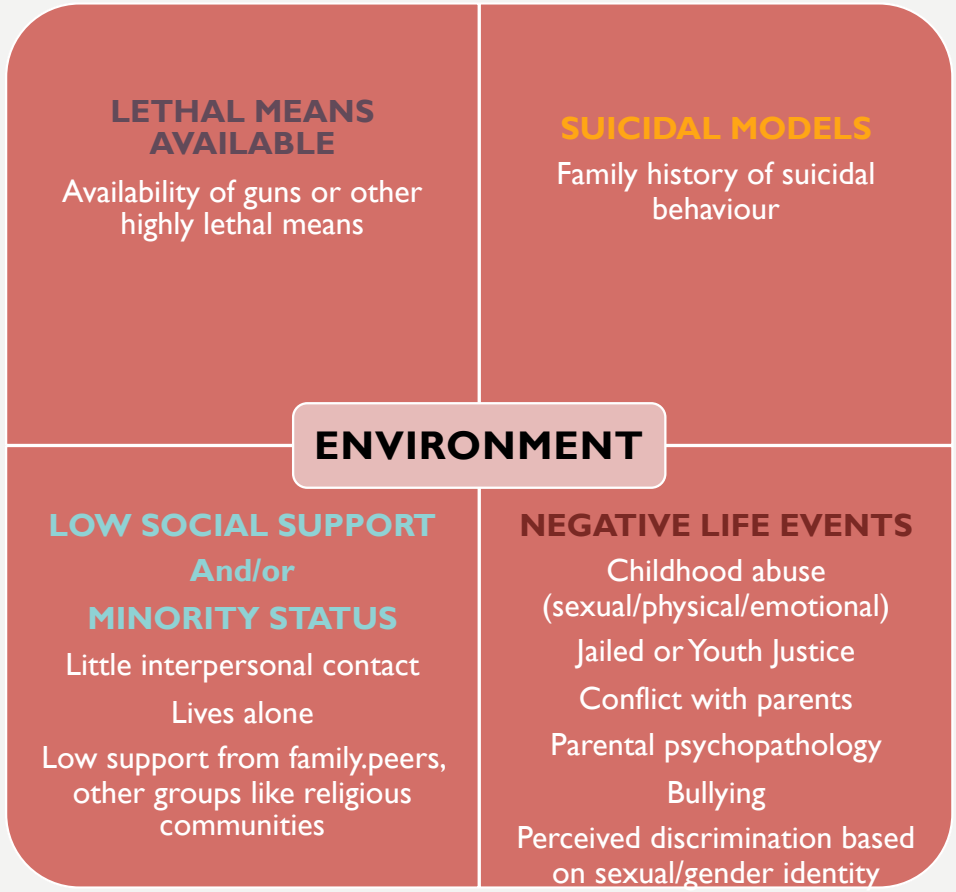
ENVIRONMENT



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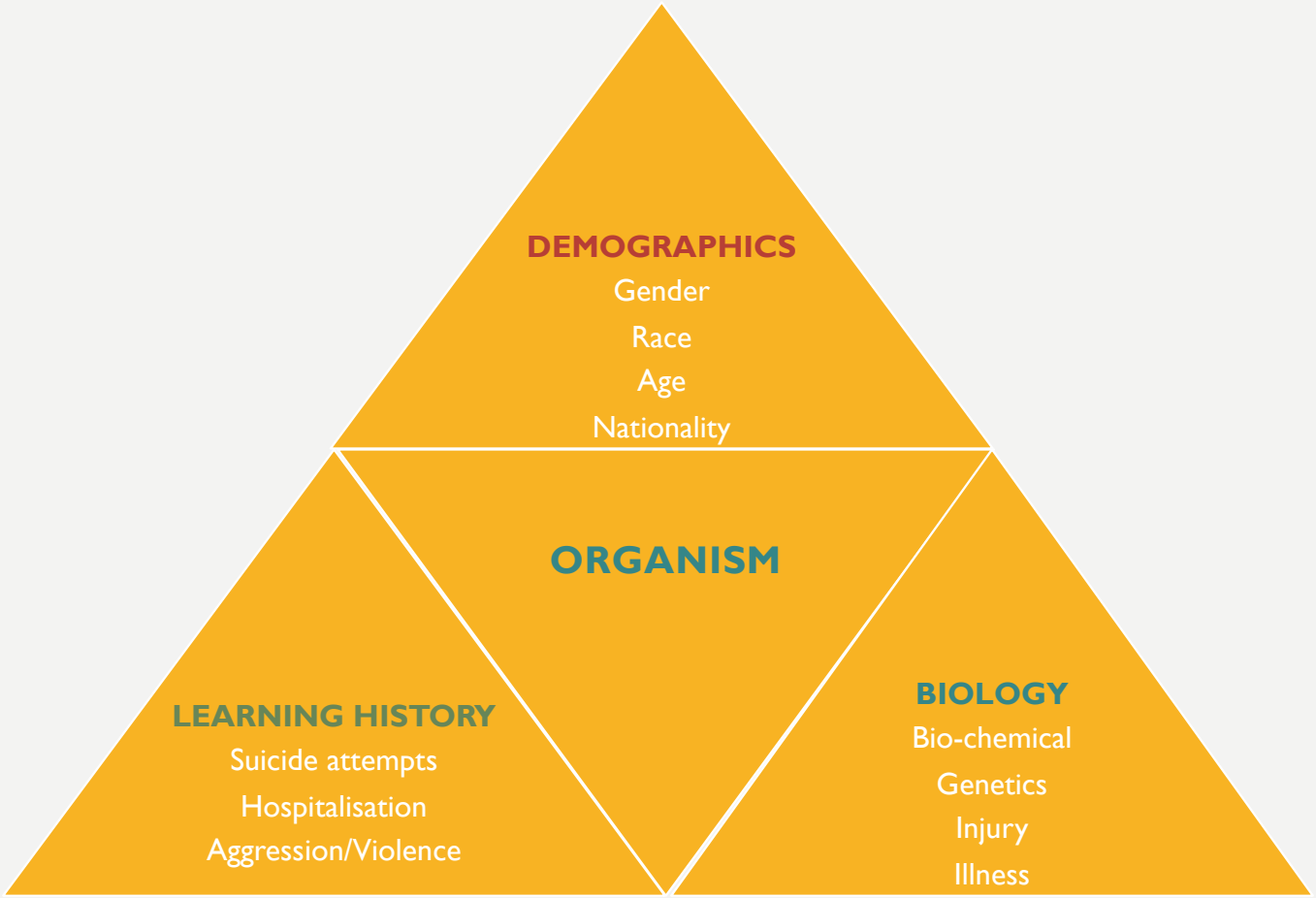
ORGANISM



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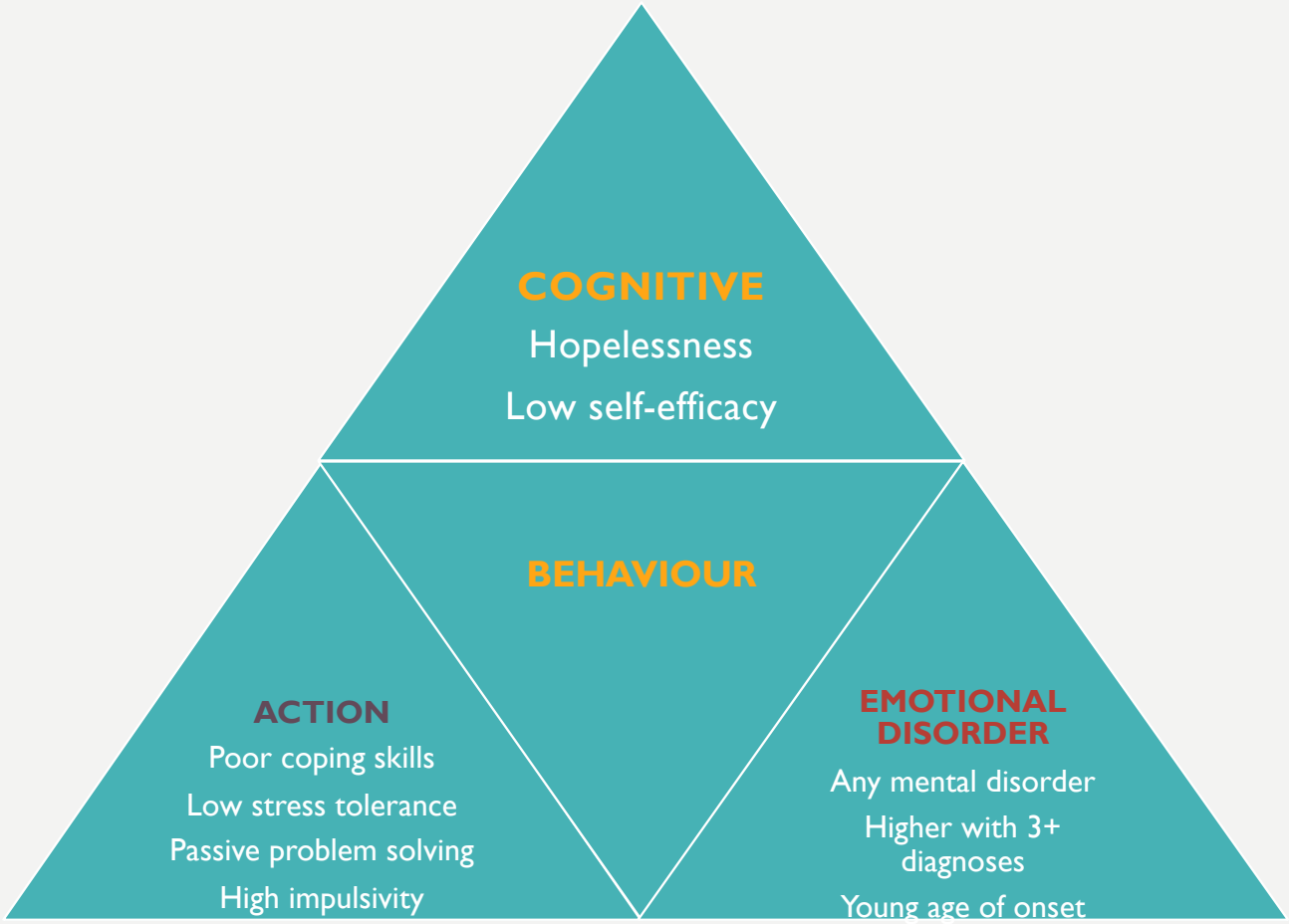
BEHAVIOUR



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JOE –CASE EXAMPLE EXERCISE

Joe is 16 year Māori and NZ European boy. He lives in Auckland with his single mother who struggles with depression. His father died by suicide during a jail term. He moved with his mum to Auckland a year ago, for a receptionist job after she was unemployed for a while and have not got meet a lot of people up her. Joe goes to co-ed low decile school, although his attendance is poor and has been throughout his time there. Joe has some learning difficulties, attention problems, and has never thought he would amount to much, a feeling that has deepened over the last year. He can't see how things would get better and figures he may as well aim to have a "good life not a long life". He recently got his restricted licence and has a cheap car, he has accrued a few speeding fines and driving out of curfew warnings already.

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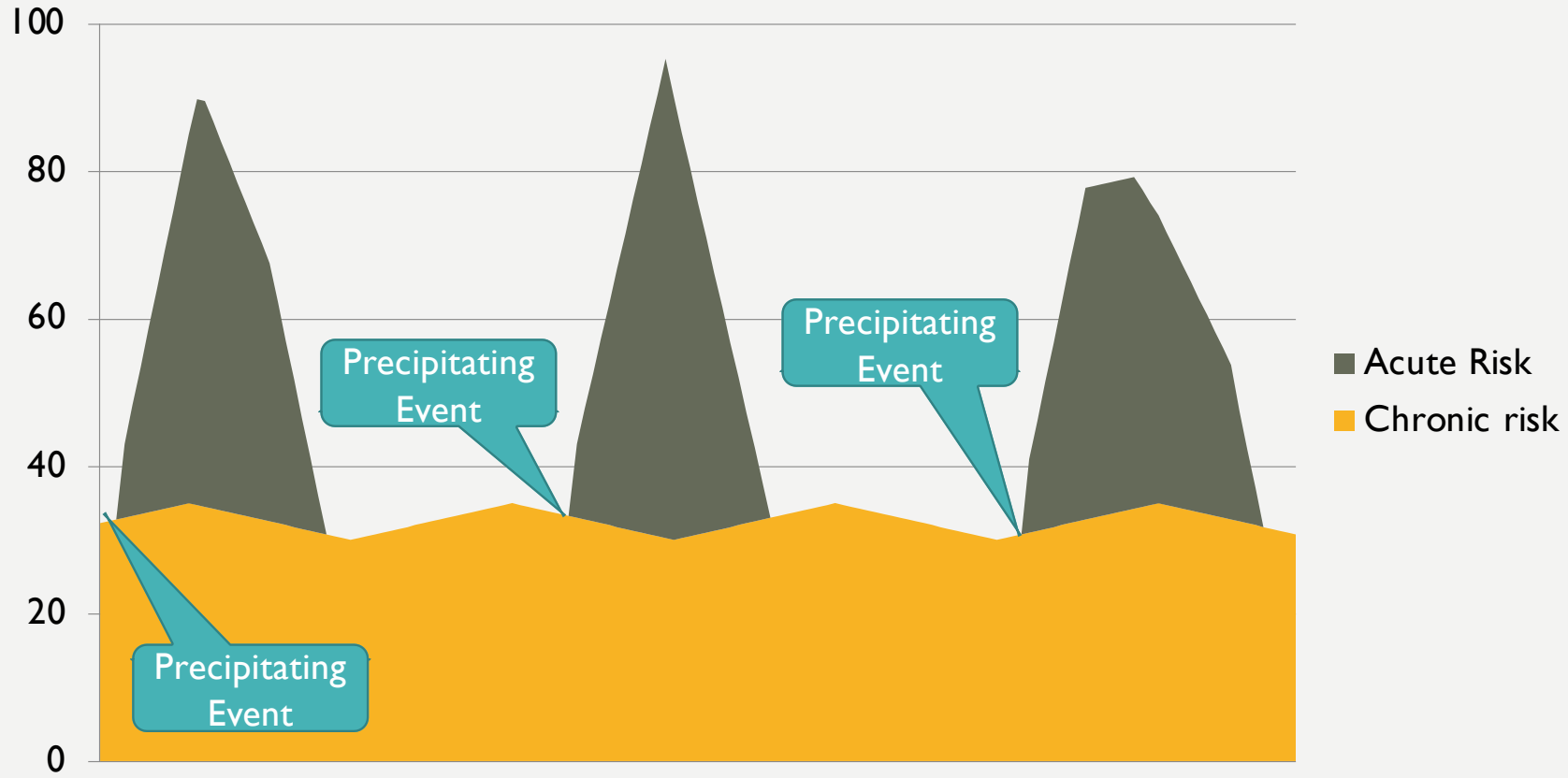
ACUTE SUICIDE RISK



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ACUTE SUICIDE RISK
WHEN TO ASSESS MORE?

- At intake or when you have not seen client in a while
- New report of suicidal ideation or self harm urges
- Increases in frequency and/or intensity of suicidal ideation or self harm urges
- Reports of suicidal communication since last contact
- Suicide attempt or self harm since last contact
- Presentation has changed since last contact e.g. client appears lower in mood or more anxious, more withdrawn and less communicative, no future orientated talk

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ACUTE SUICIDE RISK
TIMES OF HIGHER RISK

- Recent stressful events
- Recent diagnosis of mental or physical illness
- Recent discharge from Hospital
- First day after being in police custody
- Exposure to recent suicide (Family, Peers, Community, Media)
- Is or will be alone
- Acute intoxication
- Gained access to lethal means

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ACUTE SUICIDE RISK
RED FLAGS OR DIRECT INDICES

- SUICIDAL IDEATION
  - Passive thoughts about wanting to be dead
  - Active thoughts about suicide
- SUICIDAL COMMUNICATION
  - Indirect "I wont be around much longer"
  - Active "I want to kill myself"
- SUICIDAL PLAN, PREPARATION, REHEARSAL
  - Specific time and/or method, acquiring means, writing suicide notes
- SUICIDAL INTENT
  - Belief that they will kill or hurt themselves

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"A current preoccupation , preparation, or plan for suicide is the most important to inquire about, but if denied, the clinician should not conclude that suicide risk is low"

LESS THAN 20% OF PATIENTS WHO SAW THEIR CLINICIANS ON THE DAY THEY SUICIDED ADMITTED SUICIDAL IDEATION

Fawcett (2013)

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ACUTE SUICIDE RISK
ORANGE FLAGS OR INDIRECT INDICES

- Perceiving themselves as a BURDEN TO OTHERS
- Severe HOPELESSNESS and/or PESSIMISM
- LOSS OF PLEASURE in usual activities (Anhedonia)
- Increasing AGITATION, ANXIETY, or RESTLESSNESS
- COMMAND HALLUCINATIONS urging suicide
- Inability to CONCENTRATE or make DECISIONS
- SLEEPING too much or too little
- Increased, excessive, use of ALCOHOL or DRUGS
- Preoccupation with anticipated LOSS or STRESSOR
- Precautions against discovery, DECEPTION or CONCEALMENT.

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ACUTE SUICIDE RISK PROTECTIVE FACTORS

- HOPE for the future
- Sense of SELF-EFFICACY
- Attachment to BEING ALIVE
- Valued RESPONSIBILITY to family, friends, pets, etc…
- Protective SOCIAL NETWORKS
- ATTACHED TO THERAPIST
- FEAR OF DYING, pain, failed attempt, etc…
- Fear of SOCIAL DISAPPROVAL for suicide
- Belief that suicide is IMMORAL or will be PUNISHED in the after life
- Strong SPIRITUAL beliefs that don't approve of suicide

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ZOE –CASE EXAMPLE EXERCISE

Zoe is 15 year Korean girl who has been seeing you for Social Anxiety. She presents as sullen, over dressed for the weather, and often incongruent in her demeanour and reports. She lives in the boarding house of a Private Girls School and her family live in South Korea. Her girlfriend recently broke up with her, and since then she is struggling to attend in class, she is sleeping most of the day when she is not at school, and she worries a lot about what others might think about her now that she is not with Lilly anymore, who she perceives as more popular than her. Consequently she avoids most social events and has been spending most breaks in the library, something the SGC told you, with Zoe reporting that all is fine socially. There is concern from the boarding house that she is not attending all meals and she was uncharacteristically found with some RTDs in her room. She says that she kind of wishes she could get COVID so she could not have to deal with live anymore. She worries about her little sister back home who she stays in touch with regularly.

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ASKING ABOUT SUICIDALITY

GENERAL TIPS

- Establish rapport
- Clarify confidentiality
- Monitor own responses → empathy → validation
- Ask how you want them to feel when answering
  - Appear calm, allow time
- Ask direct questions (does not increase risk!), without being confrontational
- Gain collateral history

EXAMPLES OF WAYS TO ASK GRADUALLY

- How's life going in general?
- How does the future look?
- Do you ever feel life sucks?
- Does it ever feel life's not worth living / you'd rather be dead?
- Have you ever/recently thought of hurting or killing yourself?
- Often when people feel like… they think about hurting or killing themselves, have you thought about that?

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EXPLORING SUICIDALITY – ESSENTIAL DETAILS

- Previous attempt(s)
- Frequency & intensity of thoughts
- Motivation
- Acceptability of suicide
- Sense of control
- Planning & preparation
  - most impulsive
- Expectation of lethality
  - often different to that of family/clinicians – so always ask
- Current view about attempt (regret/non-regret)
- Future orientation/hope
- Access to methods
- Change required to refrain from future attempts

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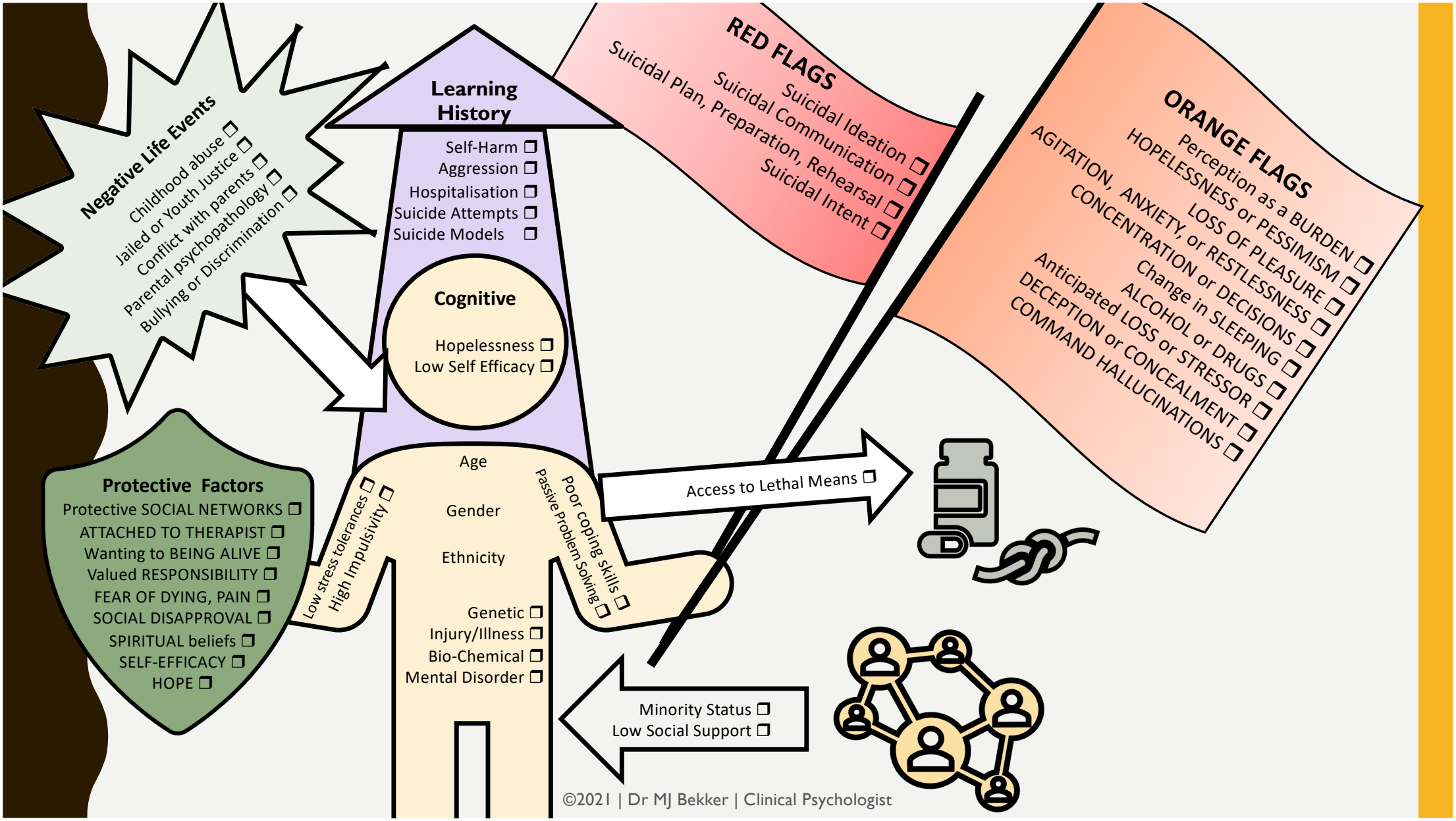
Negative Life Events
Childhood abuse ❒
Jailed or Youth Justice ❒
Conflict with parents ❒
Parental psychopathology ❒
Bullying or Discrimination ❒
Learning History
Self-Harm ❒
Aggression ❒
Hospitalisation ❒
Suicide Attempts ❒
Suicide Models ❒
Cognitive
Hopelessness ❒
Low Self Efficacy ❒
RED FLAGS
Suicidal Ideation ❒
Suicidal Communication ❒
Suicidal Plan, Preparation, Rehearsal ❒
Suicidal Intent ❒
ORANGE FLAGS
Perception as a BURDEN ❒
HOPELESSNESS or PESSIMISM ❒
LOSS OF PLEASURE ❒
AGITATION, ANXIETY, or RESTLESSNESS ❒
CONCENTRATION or DECISIONS ❒
Change in SLEEPING ❒
ALCOHOL or DRUGS ❒
Anticipated LOSS or STRESSOR ❒
DECEPTION or CONCEALMENT ❒
COMMAND HALLUCINATIONS ❒
Protective Factors
Protective SOCIAL NETWORKS ❒
ATTACHED TO THERAPIST ❒
Wanting to BEING ALIVE ❒
Valued RESPONSIBILITY ❒
FEAR OF DYING, PAIN ❒
SOCIAL DISAPPROVAL ❒
SPIRITUAL beliefs ❒
SELF-EFFICACY ❒
HOPE ❒
Low stress tolerances ❒
High Impulsivity ❒
Age
Gender
Ethnicity
Genetic ❒
Injury/Illness ❒
Bio-Chemical ❒
Mental Disorder ❒
Poor coping skills ❒
Passive Problem Solving ❒
Access to Lethal Means ❒
Minority Status ❒
Low Social Support ❒
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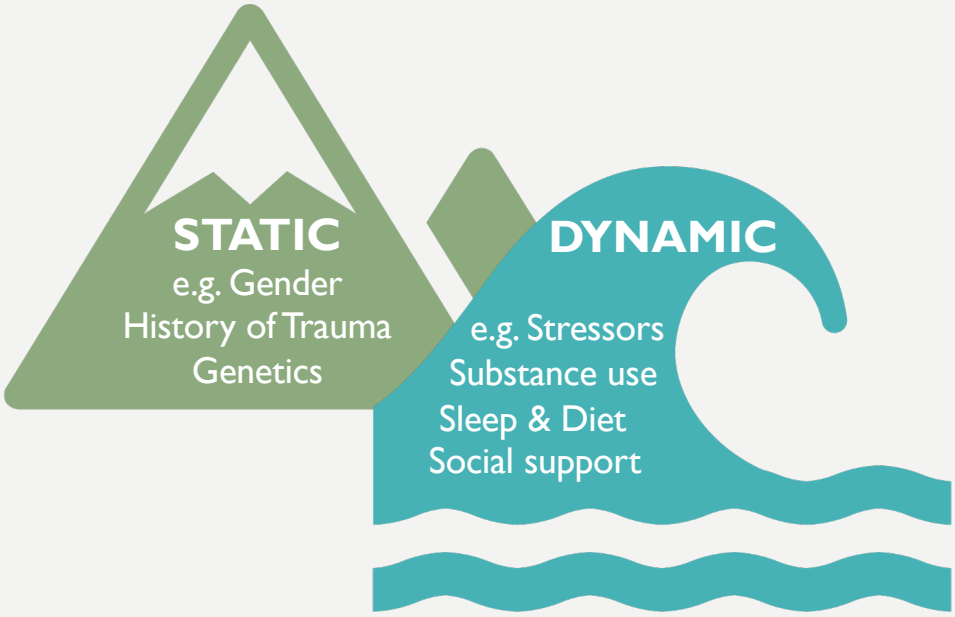
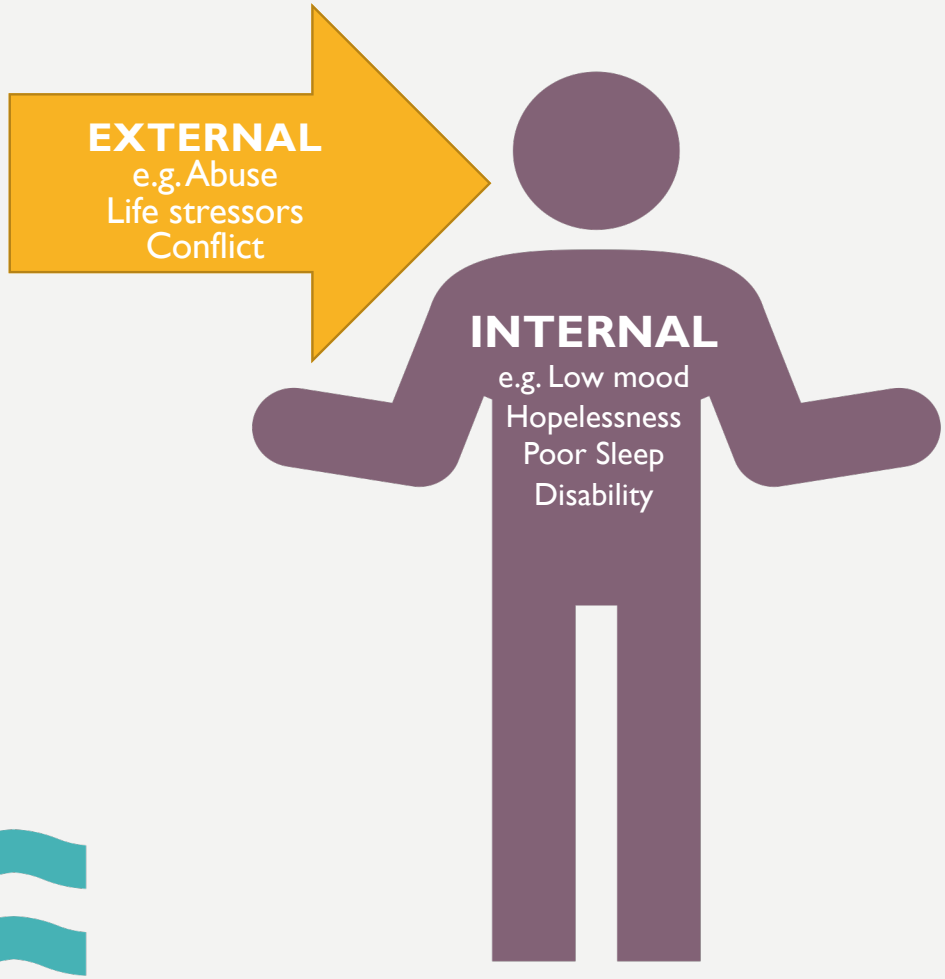
ORGANISING FACTORS THAT MODIFY RISK

Risk may be increased or decreased depending on various factors.

These can be classified as:





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RISK ASSESSMENT MATRIX

	Static	Dynamic
Internal		
External		

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RISK ASSESSMENT MATRIX

	Static	Dynamic
Internal	Previous research on methods Has self harmed Māori Male Teenager No previous suicide attempts	Suicidal Ideation & planning Shame, sadness, & anger Doesn't want to disappoint parents Wants to be a positive role model to his brother
External	Previous experience of bullying Supportive Cohesive Family	Social bullying Access to highly lethal means at home Removal of means Increased monitoring

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SUMMARISE AND COMMUNICATE ASSESSMENT

- Think **LIKELIHOOD**, **SEVERITY**, **IMMINENCE**
- Describe non-judgementally
- Be behaviourally and emotionally descriptive
- Highlight **PROTECTIVE** factors
- State clear **PLAN**

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SUMMARISE AND COMMUNICATE ASSESSMENT

Likelihood ↘

Johnathan is a 16 year old Māori male. On assessment he stated that he has been thinking of suicide, since his friends made fun of him on social media and he has been feeling shame, sadness, and anger. He has read about drinking Eucalyptus oil on the internet which is highly toxic and is fairly sure his mother has some in the bathroom and says it is easy to come by anyway. Joshua has not had previous attempts although has engaged in self harm. He denies a specific plan about when he might do it and becomes less responsive when asked about this. Joshua has supportive parents who he doesn't want to disappoint, and doesn't want to be a bad role model for his younger brother. Parents have been contacted and advised of his planned means and have removed it from the family bathroom, they have agreed to increase monitoring in and out of the home and to contact crisis team if concerned about his immediate safety, which they are willing to do.

Severity →

Protective →

← Imminence

← Plan

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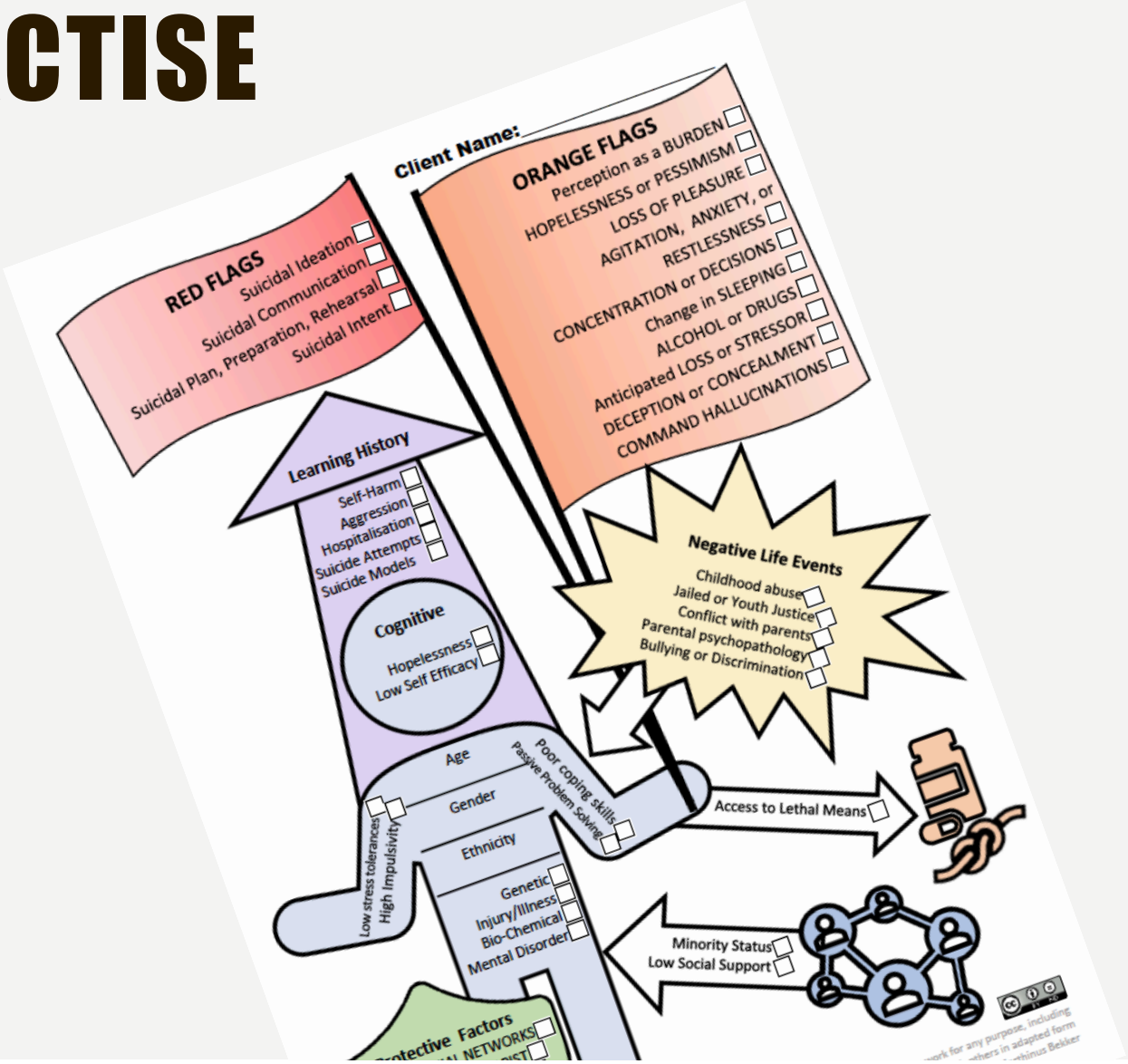
PRACTISE


Client Name:
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Ethnicity
Genetic
Injury/Illness
Bio-Chemical
Mental Disorder
Low stress tolerances
High Impulsivity
Poor coping skills
Passive Problem Solving
Access to Lethal Means
Minority Status
Low Social Support
Protective Factors

JOSH –CASE EXAMPLE EXERCISE

Josh is a 13 year old Samoan/European boy. He comes from a strict religious family and there has been concerns about the appropriateness of extended family members living in their home (uncle & older cousins). Josh has been depressed for most of this year and his mother is struggling to help him as she is dealing with her own mental health. He has been referred to week long school holiday adventure course, he showed up to the first day abut not the second (caregivers not able to be contacted) and on the third he shows up late, he looks notable more reserved with his hoodie over his head despite it being a hot day and barely participates in anything. When a staff member talks to Josh he says 'nothing is wrong'. He smells of alcohol and avoids conversation. When pressed he states that no one gives a f&*% and wouldn't notice if he disappeared. After a while Josh admits he went an hung out at a car park building in the city yesterday and drunk beers he stole from a convenience store.

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SO…
WHAT CAN I DO?

BRIEF CLINICIANS' RESPONSE TO SUICIDAL AND SELF HARMING BEHAVIOUR

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VALIDATE VALIDATE VALIDATE

- **Pay Attention**
- **Reflect Back**
- **"Read Minds"**
- **Understand** Look for how the other persons feelings, thinking or actions make sense given their past experiences, present situation, or current state of mind. *e.g. it makes sense that you think your friend doesn't care given that it's the second time they've cancelled on you.*
- **Acknowledge the valid** Look for how the person's feelings, thinking or actions are valid responses because they fit current facts, or because they are a logical response to current facts. *e.g. it makes sense that you're worried about doing a speech; most people get nervous about speaking in front of large crowds.*
- **Show equality** Be yourself! Don't "one up" or "one down" the other *person. Treat the other as an equal, not as fragile or incompetent.*

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BEHAVIOURISM

	INCREASE BEHAVIOUR "REINFORCERS"	**DECREASE BEHAVIOUR** "PUNISHERS"
ADD SOMETHING "POSITIVE"	**POSITIVE REINFORCEMENT** • Adding something desirable • Wanted attention	**POSITIVE PUNISHMENT** • Adding something unpleasant • Disapproval • Detention • Unwanted attention
REMOVE SOMETHING "NEGATIVE"	**NEGATICE REINFORCEMENT** • Avoidance • Removal of something unpleasant e.g. Intense painful emotions	**NEGATIVE PUNISHMENT** • Removing something desirable • Loosing privilege or freedoms

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IN A CRISIS

Environment

* Reduce access to lethal means
* Change suicidal models
* Increase social support
* Remove or reduce stressful events or demands

Behaviour

* Pay attention to affect rather than content
* Generate hope and reasons for living
* Activate behaviour
* Block immediate maladaptive responses (e.g. yes, but statements)

Problem Solve

* Focus on Current Problem
* Empathically tell the patient not to attempt suicide or self harm
* Give advice and make direct suggestions
* Offer Solutions
* Clarify and reinforce adaptive responses

Get a Commitment

* Explicitly ask for a commitment
* Sell Action Plan
* Ask for a lot, take a little
* Get a little, then ask for more!
* Remind Person of Previous Commitments

Trouble Shoot

* Identify factors that will interfere immediately and longer term
* Come up with a revised plan
* Ask "what if?"
* Develop a back up plan
* Schedule Check- in

Reassess Suicide Risk

Don't Assume:

* Suicide Ideation is gone
* Suicide risk won't come back

ASSESS RISK AT THE END OF INTERACTION

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REMEMBER

- The fundamental aim is to discourage maladaptive help seeking behaviour, (e.g. daily crises), and encourage useful contact and client coping.
- Remember that these clients are finding things hard. They don't set out to be difficult. (It just seems that way).
- At times of being distressed, these clients can often also have quite well developed survival skills and can be resourceful when this is required.
- There is a risk of self harm. But it is probably not as high as it appears in the middle of a crisis.
- Consistent, 'matter of fact' and de-escalating responses work well.

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A FEW MORE THOUGHTS…

- Be available for emotional crises and less warm for physical emergencies
- Assess what the young person was wanting to achieve with self-harm (function – also safety – was it a suicide attempt?)
- Be 'matter of fact', and behaviourally descriptive when talking with other people.
- Ask open-ended questions and don't be afraid to ask about suicide
- Try to avoid reinforcing self-harm while also attending to physical needs, and managing risk
- If the young person repeatedly shows up intensely distressed, develop a collaborative plan with them (at the time they are not upset) about what they can do to re-regulate and soothe themselves with your help, with the goal of bringing their emotions down, so you can get back to therapy.
- Reward effective use of skills later on at a mutually agreeable time – brainstorm reinforcers.

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ASSESSMENT OF RISK OF VIOLENCE

- Need a structure – similar to assessment of risk to self
- Current and past record of violence and threats.
  - Risk behaviours (exactly what happened?)
  - Internal factors (mental state, specific psychotic symptoms, etc)
  - External factors
  - Outcomes of previous incidents
- Can be done collaboratively with young person & family/whanau
- Protective factors may be where the potential for change is best….

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RISK ASSESSMENT MATRIX

	Static	Dynamic
Internal	Male Age Childhood problems with early onset Educational/Employment problems Previous pattern of aggression Personality traits of narcissism and psychopathy (measurable in adolescents?)	Current stated intent or threats to commit violence: thoughts/intent/plans Delusions: persecution/control/passivity/jealousy/grandiosity Hallucinations: command Suicidal thoughts Poor insight/empathy for previous victims
External	Poverty/poor social situation	Exposure to destabilisers/interpersonal or financial stressors/major life events Substance abuse/intoxication/withdrawal Lack of engagement with mental health services Non-adherence to with medication (where relevant) Systemic problems: lack of coordinated care plan/ information sharing Access to weapons/potential victims.

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PROTECTIVE FACTORS AGAINST VIOLENCE

Less clear from the literature

Possibly:

- Family/whanau factors
- Social Support
- Skills and success in any field
- Suggestions?

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LESSONS FROM INQUIRIES

ADAPTED FROM TE POU

- Poor communication
- The failure to take the reports of others seriously
- Undue emphasis on a narrow concept of liberty, therefore reluctance to use compulsory Rx where indicated
- Tendency towards cross-sectional assessments ("He seems ok now…")
- Failure to share information

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What is...

RISK?

FROM OTHERS

Neglect
Abuse
Violence
Homicide

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OUR STATS AREN'T GREAT…

- Approximately 4 percent (1 in 25) have experienced severe physical punishment from a parent
- Approximately 1 in 5 children have experienced regular physical punishment by their parents
- Among contemporary young NZ parents (under the age of 25), 77 percent reported that they had physically punished a child, and 12 percent had severely punished a child
- Approximately 1 in 4 girls have experienced some form of unwanted sexual touching by the time they are 15 years old. Approximately 1 in 16 boys have experienced this form of abuse

- 50 percent had witnessed an adult yelling or swearing at another child
- 48.3 percent had witnessed adults yelling or swearing at each other
- 13.9 percent had witnessed an adult hitting or physically hurting another child
- 7.4 percent had witnessed adults hitting or physically hurting each other
- 14.1 percent had themselves been hit or physically hurt by an adult

- Overall findings show that 1 in 3 New Zealand women have experienced physical and/or sexual violence by a male intimate partner in their lifetime, 1 in 20 women in the previous 12 months.
- Data from the New Zealand Crime Victimisation Survey indicates that 18 percent of men have experienced IPV in their lifetime

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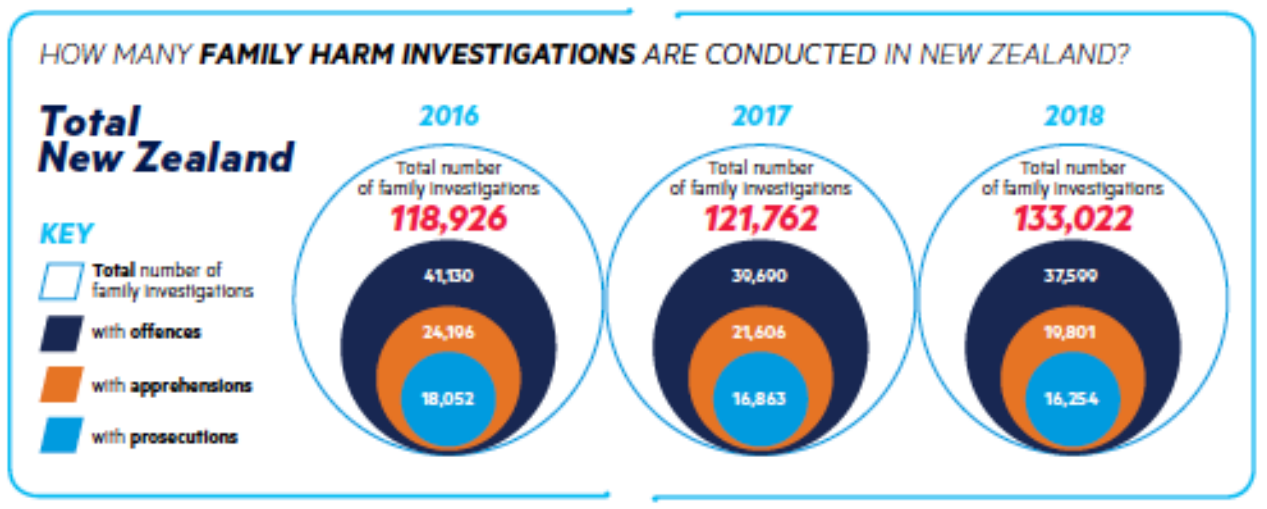
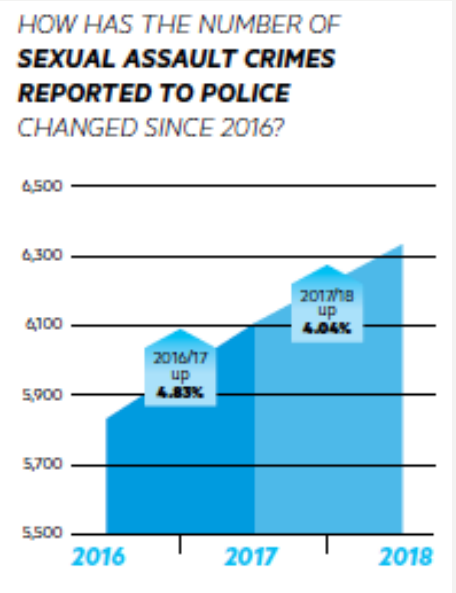
NZ POLICE DATA
2019 'YOU ASKED US' REPORT





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ROUTINE DOMESTIC VIOLENCE QUESTIONS

Can be framed: 'We know that family violence is common and affects women's and children's health, so we are asking routinely about violence in the home.'

- 'Within the past year, did anyone scare you or threaten you, or someone you care about? (If so, who did this to you?)'
- 'Within the past year, did anyone ever try to control you, or make you feel bad about yourself?'
- 'Within the past year have you been hit, pushed or shoved, slapped, kicked, choked or otherwise physically hurt? (If so, who did this to you?)'
- 'Within the past year has anyone forced you to have sex, or do anything sexual, in a way you did not want to? (If so, who did this to you? When did this happen (the last time?)'

Fanslow J L, Kelly P, Ministry of Health. 2016. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (2nd edn). Wellington: Ministry of Health.

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ANY QUESTIONS?

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