BPD Webinar Series:

Towards a National BPD Training and Professional Development Strategy

Australian BPD Foundation Limited

spectrum
Personality Disorder Service for Victoria
www.spectrumbpd.com.au
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Webinar 5
Management of self-injury and suicidality

Wednesday 26th September 2018
7:15 PM - 8:30 PM (AEST)

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Webinar Series

This is the fifth webinar of a National BPD Project funded by the National Mental Health Commission. If you didn't attend the first four webinars, visit the Australian BPD Foundation website. This webinar will cover self-injury and suicidality.

The last webinar in the series will address:

Webinar 6: Management in mental health services, primary & private sectors - 26th November, 2018 at 7:15 PM-8:30 PM (AEDT)

Tonight's Panel

Pip Bradley
Mental Health Nurse

Melissa Kent
Psychologist

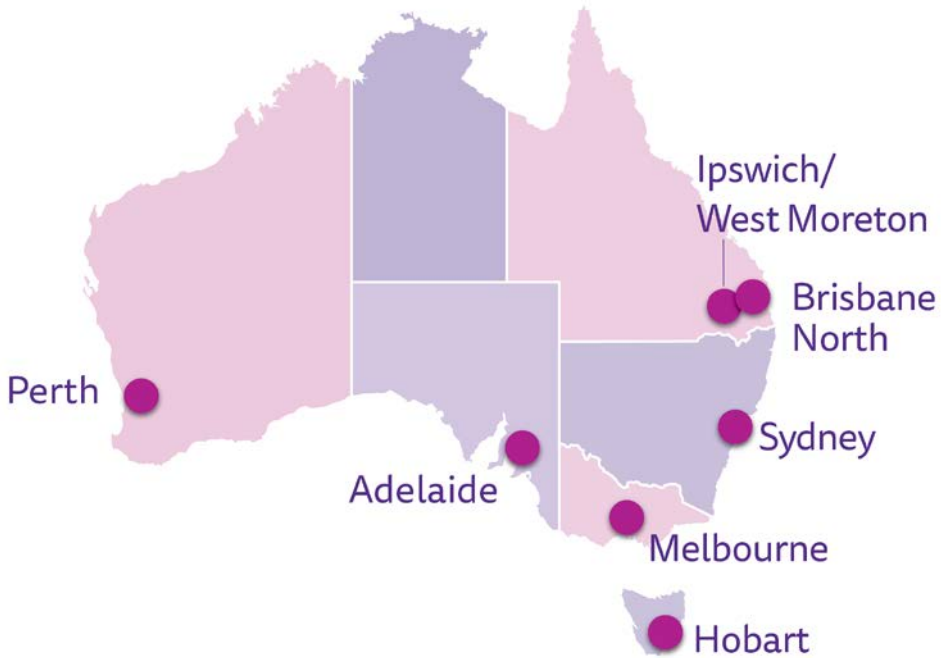
Facilitator

Mahlie Jewell
Lived Experience Advocate

Dr Lyn O'Grady
Psychologist

Practitioner Networking Opportunities

Seven practitioner networks provide a forum for practitioners with a shared interest in BPD. Visit www.mhpn.org.au (news section) or contact MHPN to learn more.



Audience tip:
Download the fact sheet in the resources tab to learn more about BPD practitioner networks.

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 you would in a face-to-face activity.
- For help with your technical issues, click the Technical Support FAQ tab at the top of the screen.
- If you still require support, call the Redback Help Desk on 1800 291 863. If there is a significant issue affecting all participants, you will be alerted via an announcement.

Audience tip:
If you are having difficulties with the audio, please dial in on 1800 896 323
Passcode: 2353870818#.

Learning Outcomes

Through an exploration of Borderline Personality Disorder (BPD), the webinar will provide participants with the opportunity to:

- outline non suicidal self-injury and suicidality in BPD
- analyse risk factors for suicide in BPD
- implement management strategies for non-suicidal self-injury and suicide risk.

Audience tip:
The PowerPoint slideshow and case study can be found in the Resources Library tab at the bottom right.

Mental Health Nurse Perspective

Self-Harm and Suicide Rates

- 75% of people with BPD self-harm
- 65% to 70% will attempt suicide at least once in their lifetime
- A higher lifetime number of attempts at suicide is related to higher lethality methods and greater risk of death
- 10% complete suicide
- 25% of suicide attempts for people with BPD are with prescription medications
- It is very difficult to predict accurately who is at risk of suicide
- It is difficult to differentiate between intent to self-harm and intent to suicide

Pip Bradley

Mental Health Nurse Perspective

Assessing Risk

Focus on the lethality and acuity of self harm/suicidal actions and causes underlying changes in these.

Acute Risk:

Acute risk refers to high acuity mental state and high lethality behaviours that increase the risk that a person may die.
There may be a deliberate intention to die, with preparation and a plan of sufficient lethality, generally with changes or escalations in the behavioural risk pattern.

Chronic Risk:

Chronic risk refers to the ongoing likelihood of a person engaging in self-harm / suicidal actions based on their previous pattern of repetitive self-harm and suicidal actions, and these are utilised as attempts to manage emotional distress and life stresses.

Pip Bradley

Mental Health Nurse Perspective

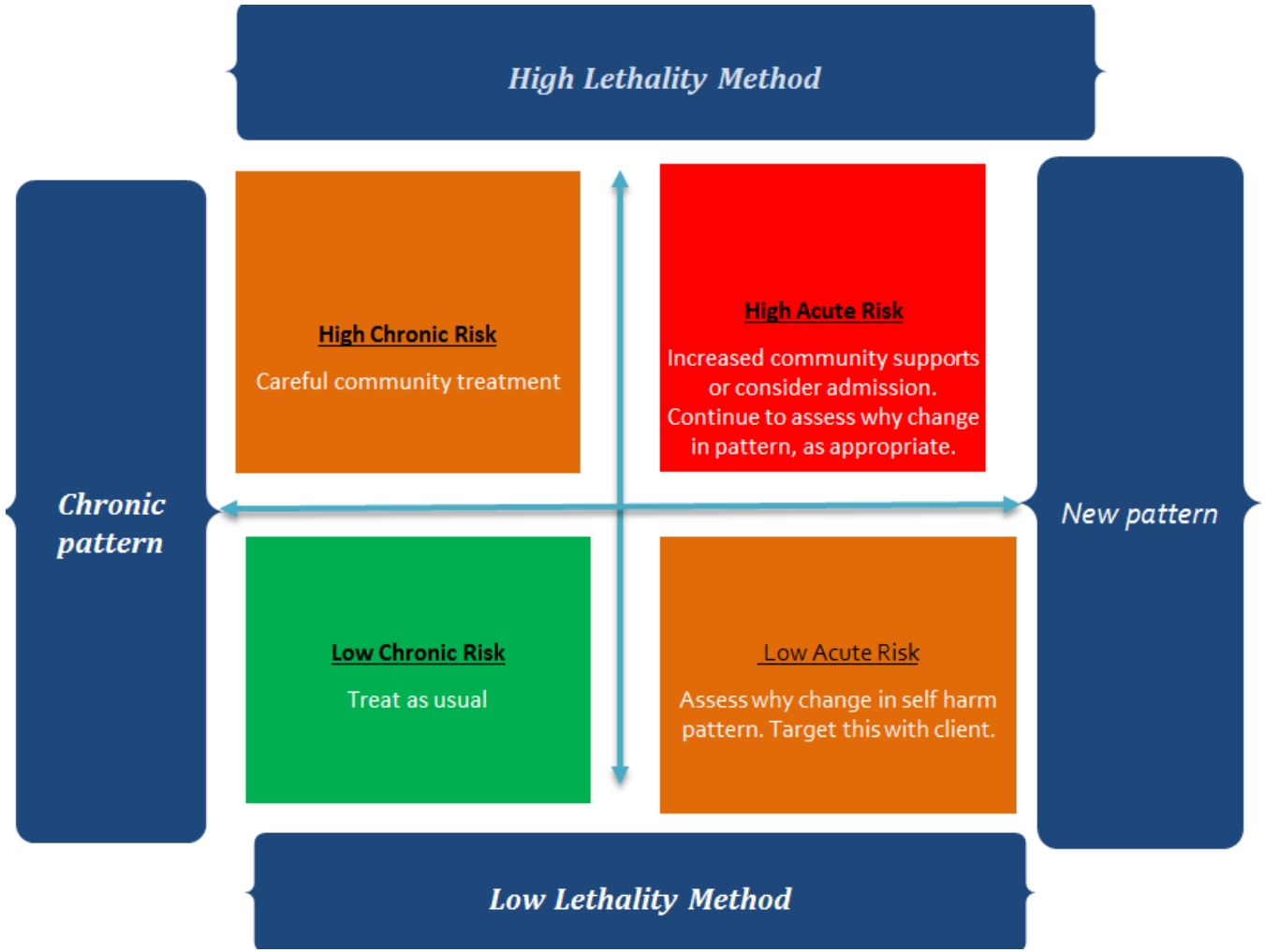
Assessing Changes in Risk Status

From a baseline formulation of static, dynamic and protective risk factors for the person (which is able to be formulated when the client is known)….

- Assess changes in the dynamic and protective factors
- Assess changes in pattern, lethality, method
- Assess the function of self-harm or suicidal actions for this person at this point in time

Pip Bradley

Mental Health Nurse Perspective

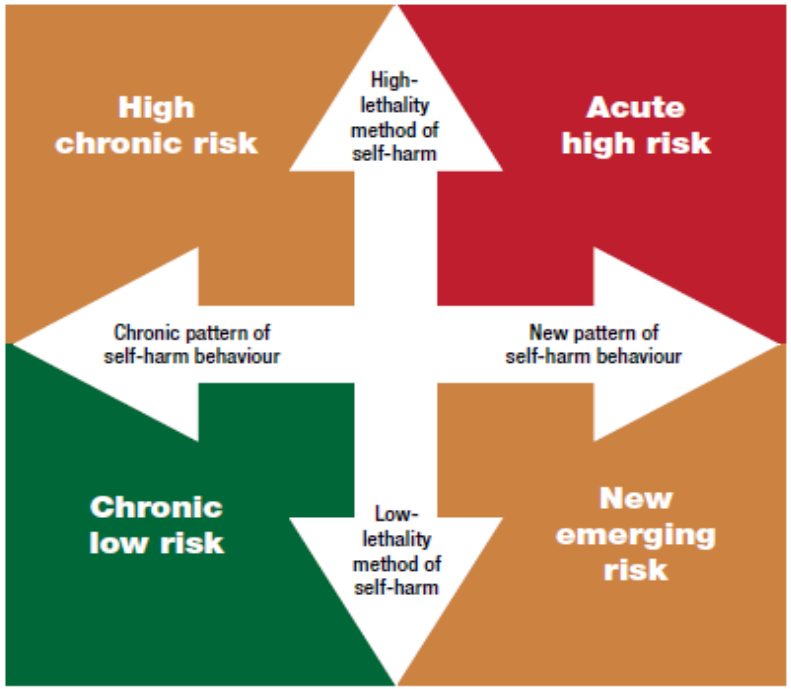


Pip Bradley

Mental Health Nurse Perspective

NHMRC guidelines for BPD-2012

Figure 8.1 Estimating probable level of suicide risk based on self-harm behaviour



Adapted from Spectrum (personality disorder service for Victoria: www.spectrumbpd.com.au)

Figure 8.1 is a guide to estimating the probable level of risk in a person with BPD who self-harms, by considering the pattern and lethal potential of self-harm. However, risk may change suddenly or be difficult to predict based solely on the signs and symptoms available to the clinician. Frequent review, a trusting therapeutic relationship and helping the person to build a strong support network are necessary to help keep the person safe.

Pip Bradley

Mental Health Nurse Perspective

Therapeutic Risk Management

- Treatment gains are made when clients are given the opportunity to be supported through high levels of emotional distress while remaining in the context of their life

- If hospital or other increased support options are used for assessed risk acuity, they should be brief, as the acute pattern will settle in a few days, and the chronic pattern will likely return and can be further reinforced by the admission

Pip Bradley

Mental Health Nurse Perspective

Therapeutic Risk Management When Client Is Known

- Have a good assessment and formulation that can lead to a meaningful treatment approach
- Understand the chronic risk pattern, have a formulation of static, dynamic and protective factors
- Develop a treatment plan that documents management of risk therapeutically in the community, balancing short term risk and long term gain
- Develop the plan as collaboratively as possible with client, and family/carers as appropriate, and all services involved
- Ideally have a primary clinician who has a therapeutic relationship with the client
- Ensure plan is signed off by manager / clinical leader and is followed by all involved

Pip Bradley

Mental Health Nurse Perspective

Risk Management When Client Is Not Known

- More conservative in assessment and management
- Need to take time to get to know client's pattern
- Ensure adequate community supports are engaged to manage safety (increasing protective factors)
- Or may consider brief admission for assessment purposes if limited community support (admission is for assessment vs management of risk)

Pip Bradley

Mental Health Nurse Perspective

"How" We do Risk Assessment and Management

- Remain empathic, validating, non-judgmental, respectful, communicating understanding of the person's experience
- Focus on the emotional state underlying suicidal communications, content often settles with sufficient validation
- Support maximum autonomy, assume competency, avoid taking responsibility
- Collaborative, involving client and family/carers in planning risk management
- Maintain a focus on longer term goals/recovery

Pip Bradley

Clinical Psychologist Perspective

Principles of Risk Assessment for a Person with BPD

Risk of suicide/self-harm fluctuates over time, so risk assessment should be ongoing, and undertaken at certain points:

- when the person first contacts a health service
- when the person begins a course of structured psychological therapy during a crisis
- if the person develops another mental illness (eg substance use disorder, depression, psychosis)
- if the person's psychosocial status changes
- at transitions between services or discharge from a treatment plan
- when their management plan is being reviewed or altered
- risk assessment should also assess whether the person's behaviour may constitute a risk of harm to others (NHMRC, 2012)

Melissa Kent

Clinical Psychologist Perspective

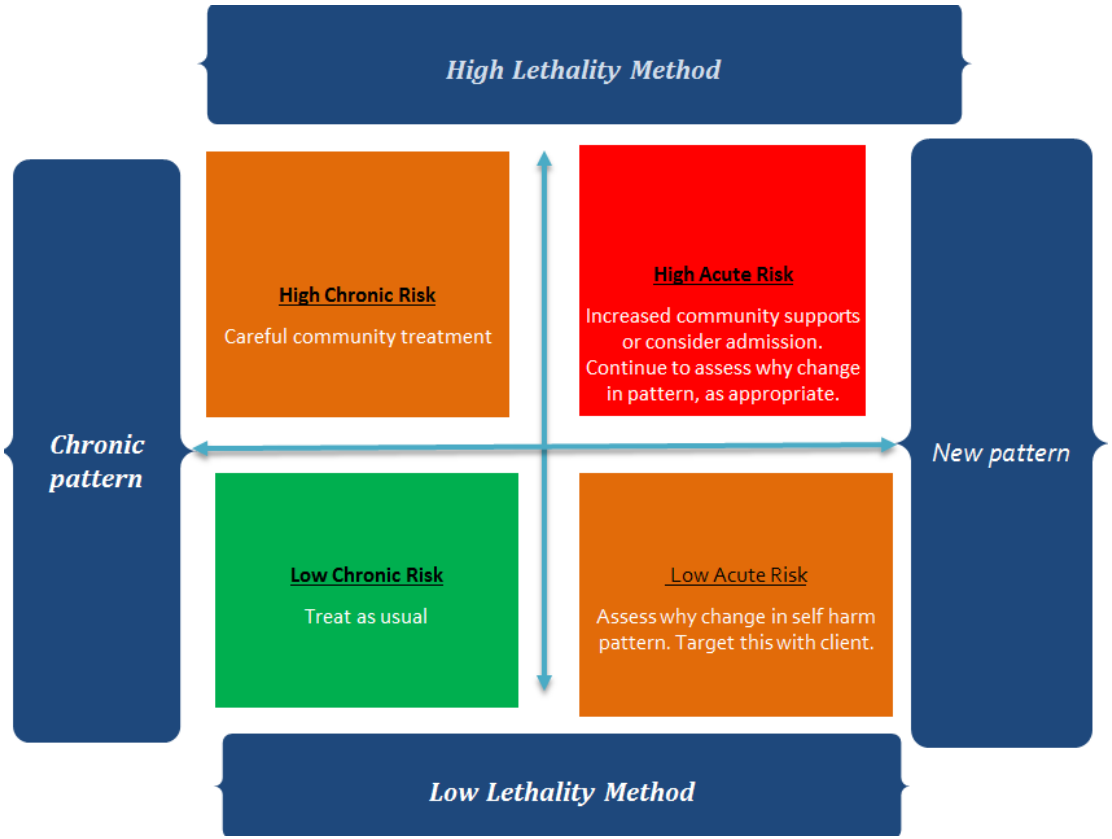
Indicators of Increased Risk in People with BPD

- Change in chronic pattern of suicidal/self-harm behaviour
- Co-existing psychotic features/depression/substance abuse - depression+ substance abuse = strongest predictor
- Impulsivity
- Incest
- Clinicians losing hope
- Clinicians becoming anxious
- High lethality attempts
- Repeated attempts in a short period of time
- Romantic relationship breakup
- Loss of a stable job or support
- Abandonment
- Sexual assault
- Substance intoxication
- Access to meds

Melissa Kent

Clinical Psychologist Perspective

Risk Assessment and Management Matrix as Applied to Rebecca



Melissa Kent

Clinical Psychologist Perspective

Risk Assessment and Management Matrix as Applied to Rebecca

- Time point - "last 3 months"

Low Chronic Risk

Treat as usual

- Time point - "last week"

High Acute Risk

Increased community supports or consider admission. Continue to assess why change in pattern, as appropriate.

- Time point - "2 weeks ago"

Low Acute Risk

Assess why change in self harm pattern. Target this with client.

- Time point – “one year later”

High Chronic Risk

Careful community treatment

Melissa Kent

Clinical Psychologist Perspective

A Word about Families, Partners and Carers

- Families, partners and carers can play an important role in supporting a person with BPD's recovery
- Self-harm can be distressing for the person's family or partner, but demands to stop this behaviour can be counter-productive and increase the person's distress. Educate and support - the person may need treatment and time before they can give up this behaviour
- Involve the person's family, partner or carers when developing and reviewing crisis plan, if possible and appropriate
- Develop a separate carer crisis plan eg NSW Health Carer Plan. How to manage suicidal crisis, reliable information about dealing with suicide attempts/self-harm, sources of support for them (Project Air, 2016)
- Encourage carers to ask questions and discuss their concerns
- Respect the person's right not to involve their family, partner or carers, if they so decide - remember this can change, so keep checking

Melissa Kent

Lived Experience Advocate Perspective

Consumer-Led Treatment

Ask Rebecca!

- No plan or treatment guideline should be done without first asking what Rebecca wants.

What is her idea of recovery?

- Her goals and treatment choices need to be up to her.
- Work from her frame of reference.
- Have patience and work on her timeline for change.

What are Rebecca's patterns?

- Rebecca often stops self harming and abusing ETOH/IS when she feels happy, safe and supported. This is a strength. Create goals around this. This is too directed around the reactions / actions / feelings of others. Interpersonal issues and identity need to be addressed - DBT.

Mahlie Jewell

Lived Experience Advocate Perspective

Unrecognised Self-harm Mechanisms

Pay attention to the things you are not trained to see, don't hear. Listen to the story not being told. Mental health workers are better when skilled in drug and alcohol, domestic violence and criminal justice patterns.

Look for:

Inappropriate relationships

- Rebecca has a history of intimate partner violence, partnerships with power and control mechanisms, partners engaged in criminal activity, etc. This feeds internal self-hate and worthlessness.

Financial decisions

- Rebecca has a low socio-economic class - how does this feed her self-harm?

Criminal offence

- Drug trade (and possession), committing criminal offenses - Rebecca's environments and community can be part of self-harm "I don't deserve better..." "This is all I know..."

Drugs and alcohol misuse

- Rebecca's ETOH/IS use is highly reactive. This is not being addressed by trained clinicians. Especially substances considered "socially acceptable" such as alcohol and prescription medication. Not monitored because of legal prescriptions, etc.

Self sabotage patterns

- Creating road blacks and barriers to achieving previously set goals, such as using "default" maladaptive coping mechanisms, she has no other options.

Mahlie Jewell

Lived Experience Advocate Perspective

Indicators of Acute Suicidality for People with Chronic Suicidality

Calm and/or relief / unusual happiness or carefree demeanour

- Acceptance that the decision of death has been made and this has meant that they are no longer concerned about their challenges and circumstances.

Change in self-harm behaviour

- Allowing wounds to become infected or harming in new ways / new sites (cutting, burning), increased episodes, increased severity.

Emotional exhaustion

- No longer interacting or wanting to “fight”.

Trouble managing persistent suicidal thoughts

- Thoughts or “voices” becoming louder, more direct, changing.

Mahlie Jewell

Lived Experience Advocate Perspective

Crisis Reaction/Treatment

Doctors/nurses - provide care without personal attachment

- Wound care should be done without judgment, and should be treated like any other physical health issue. This includes appropriate and TIMELY medical care, including pain management, quality treatment and no shaming and blaming behaviour and language.

Language is important

- Be aware that medical terminology can trigger self-hate and feelings of worthiness. Descriptors like “superficial cutting” and “minor injury” can be invalidating and lead to people self-harming in more extreme ways to feel legitimate and worthy.

Short inpatient admissions

- Can be lifesaving. Do NOT shame this, but giving it a boundary (eg, each admission is 3 days no longer) and being upfront with that and making sure to discharge to a community DBT program to stop the cycle and avoid isolating the consumer.

Scan for addictive brain surrounding self-harm

- Looking for patterns that indicate self-harm has switched into addiction behaviour as opposed to coping or soothing behaviour and accessing specialised treatment around that.

Engaging clinicians who are trusted

- Making sure that existing clinicians have input into all treatment teams (such as - private clinicians invited into inpatient settings for meetings). Clinicians should be trained in DBT.

Support systems

- These must be directed by person and SHOULD INCLUDE PEERS - CONTAGION IS NOT FACT. Do not make self-harm an auto exit in DBT programs**.**

Mahlie Jewell

Lived Experience Advocate Perspective

Ongoing Management

Gauge a baseline / tracking and reflecting on self harming behaviours

- Understand the person's standard practice using diary cards. Therapy sessions begin with analysis of diary card with person

Monitor for change in practice

- People may stop self harming in one way but then switch to another.

DBT and psychotherapy

- This is essential to ending the pattern of self-harm and chronic suicidality.

Use harm minimisation plans

- Engage the person to try and reduce harm initially, do not fixate on complete abstinence. This must be consumer-led. Prepare for and be strengths-based around relapse, don't overreact.

Encourage conversations about shame and guilt

- Address the long-term impacts of self-harm - scars, physical medical issues, brain injury and begin acceptance and processing therapies

Trust is more important than "risk assessment"

- Never employ risk strategies unless you have real cause, to avoid breaking trust with client.

Be aware

- Never assume the person is not self-harming, check in.

Mahlie Jewell

Q&A

Pip Bradley
Mental Health Nurse

Melissa Kent
Psychologist

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Lived Experience Advocate

Dr Lyn O'Grady
Psychologist

Resources and Further Reading

Spectrum and The Australian BPD Foundation have prepared a list of resources at

http://www.bpdfoundation.org.au/webinar-5.php

Audience tip:
Your feedback is important – please click the Feedback Survey tab to open the survey

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Thank You For Your Participation

- Please ensure you complete the *feedback survey* before you log out.
- Click the Feedback Survey tab at the top of the screen to open the survey.
- Certificates of Attendance for this webinar will be issued within four weeks.
- Each participant will be sent a link to the online resources associated with this webinar within two weeks.

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Thank you for your contribution and participation

Good evening

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