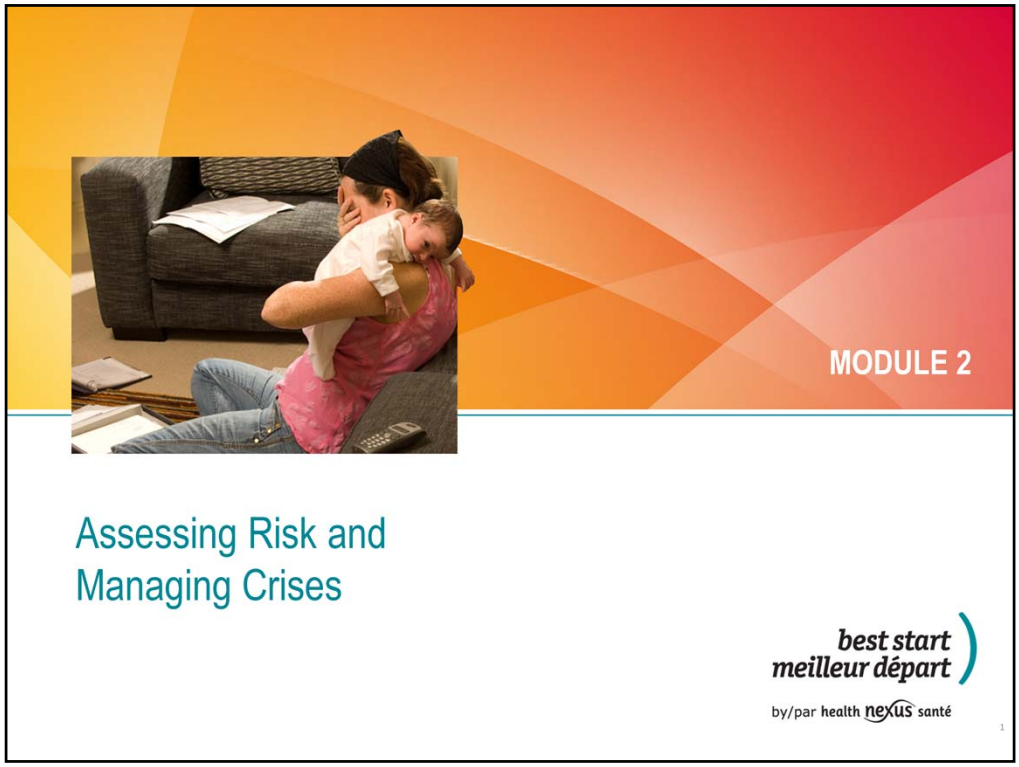


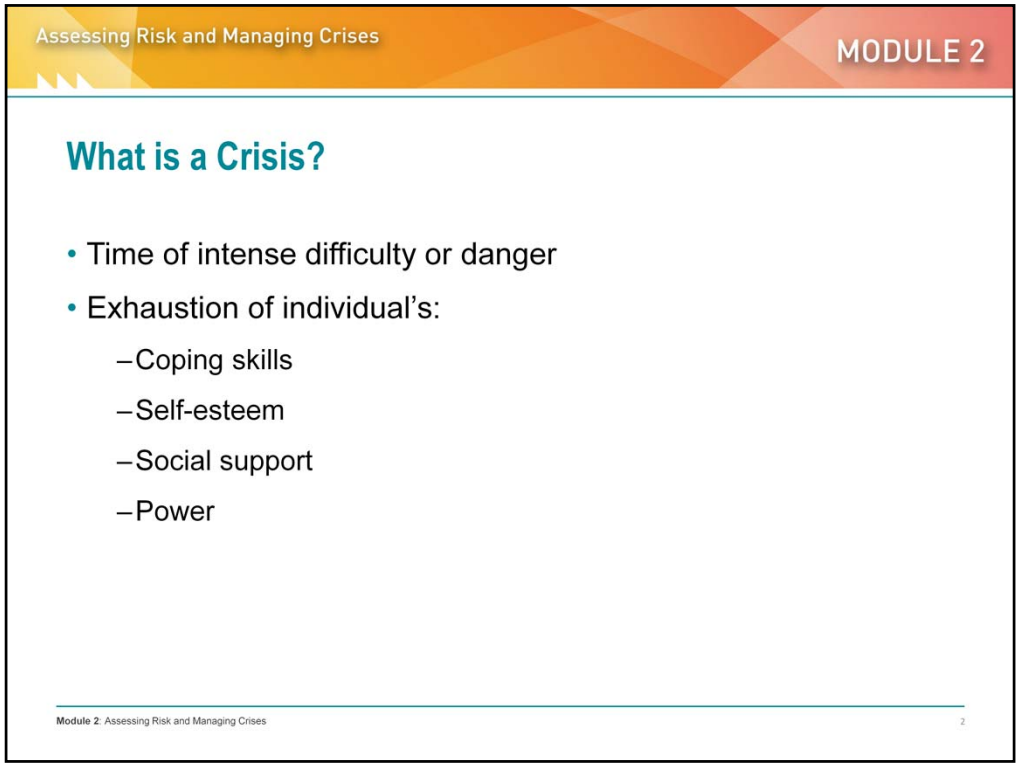
Facilitator

Suggested Pre-Workshop Preparation:

Provide handout prior to workshop or at least the list of resources at the end of the handout.

Have participants

1. Review one or two items on the list of *Resources and References* in detail; be prepared to discuss how they would be helpful.

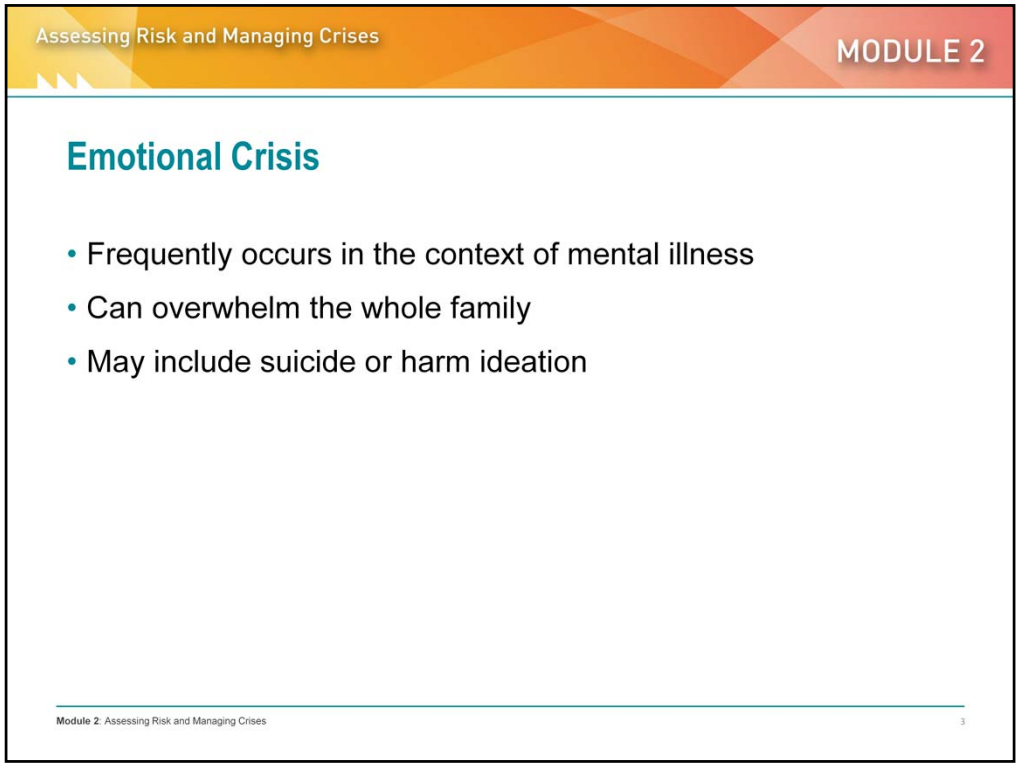


Background:
A crisis can be defined as a time of intense difficulty or danger (http://oxforddictionaries.com/definition/crisis).
A crisis moment can occur at any time an individual perceives that he/she has exhausted his/her coping skill, self-esteem, social support, and power.

Other aspects include:

- Psychological pain
- Hopelessness
- Helplessness
- Perceived burden on others
- Feeling trapped
- Feeling intolerably alone
- Increased heart rate, sweating

(Crisis intervention and trauma response: theory and practice. By Barbara Rubin Wainrib, Ellin L. Bloch)

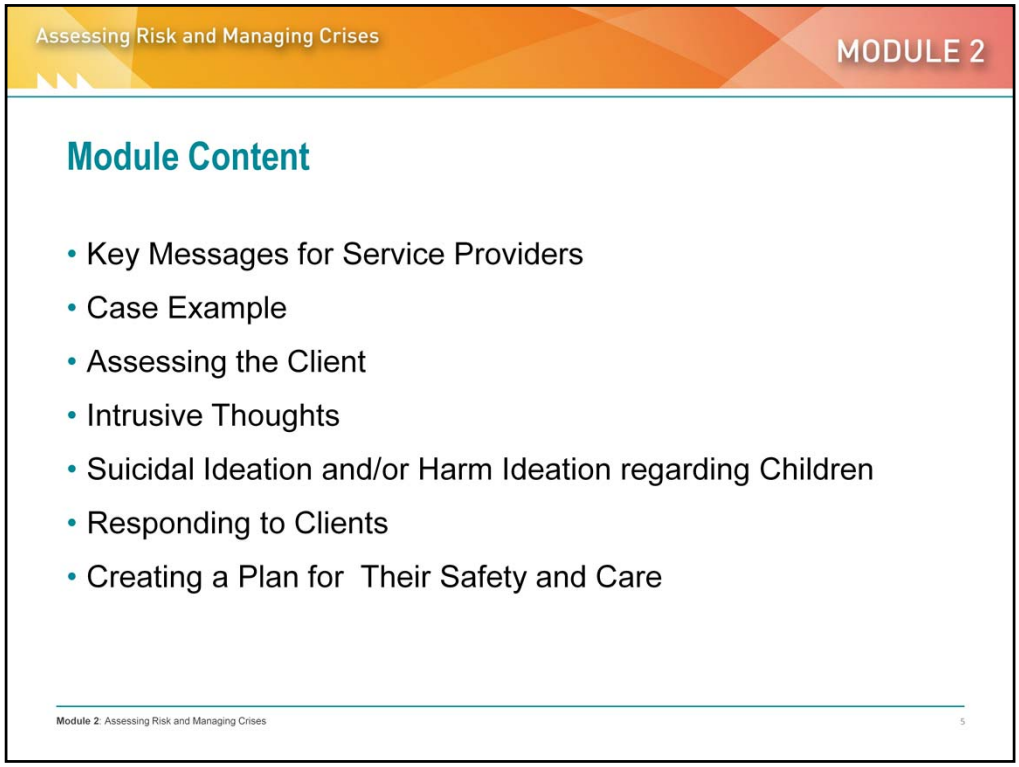


Frequently, an emotional crisis occurs in the context of mental illness, though not always. A crisis can impact and overwhelm the whole family. Occasionally, service or care providers may feel overwhelmed when their clients are in crises or when there is a perceived safety risk to the client or the children.

It is important for the health care/service provider to assess the risk for harm to the client or to others including children, and make a plan to control the risk and manage the crisis.

Module Goals

- Understanding the implications of a crisis on clients and their families.
- Assessing the client and if the client is at risk for harming self or others.
- Facilitating short-term help until additional assistance and resources can be accessed.

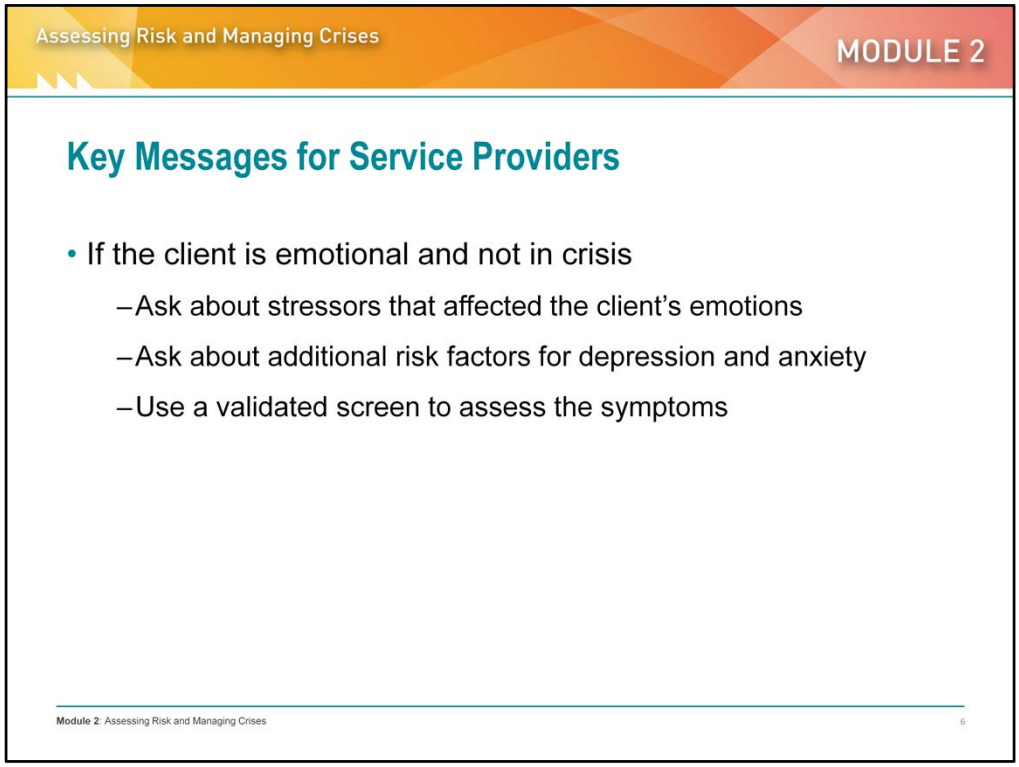


This module is organized as follows:

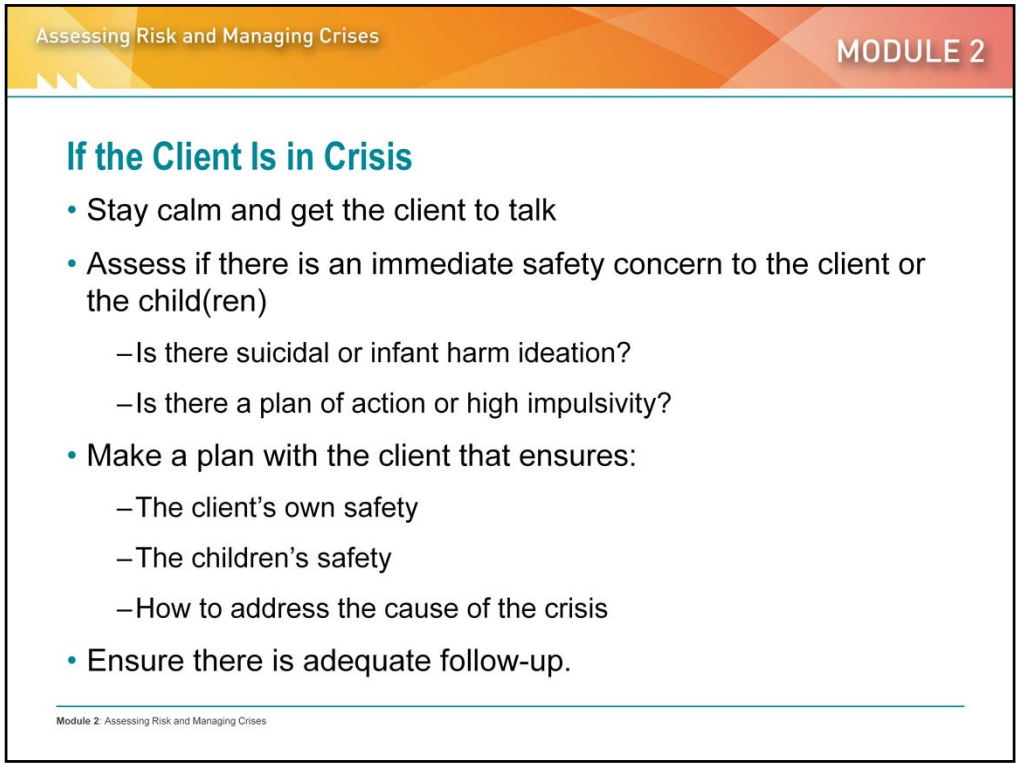
- Key Messages for Service Providers
- Case Example
- Assessing the Client
- Intrusive Thoughts
- Suicidal Ideation and/or Harm Ideation regarding Children
- Responding to Clients
- Creating a Plan for Their Safety and Care

Facilitator provide handout for participants. Handout includes:

- Case Example
- Worksheet with Questions for Reflection
- Edinburgh Postnatal Depression Scale [EPDS]
- Patient Health Questionnaire 4-item [PHQ-4]
- Creating a Safety Plan
- Resources and References



Validated screens will be discussed later in this module.



Facilitator talk about earlier slide and the definition of a crisis. Participants may have some examples.

Case Example

Lila is a single mother of a 6 week-old baby. She has been diagnosed with postpartum depression and has a history of general anxiety disorder but is not on any medications at present . When you arrive for a scheduled visit, Lila's home is a mess. The baby is crying. Lila is crying, too. She tells you her monthly financial allowance has not arrived this week and she is almost out of diapers. She cries harder and starts to hyperventilate. You try to calm her down, but she is almost hysterical and tells you the baby would be better off without her.

Facilitator discuss *Case Example.*

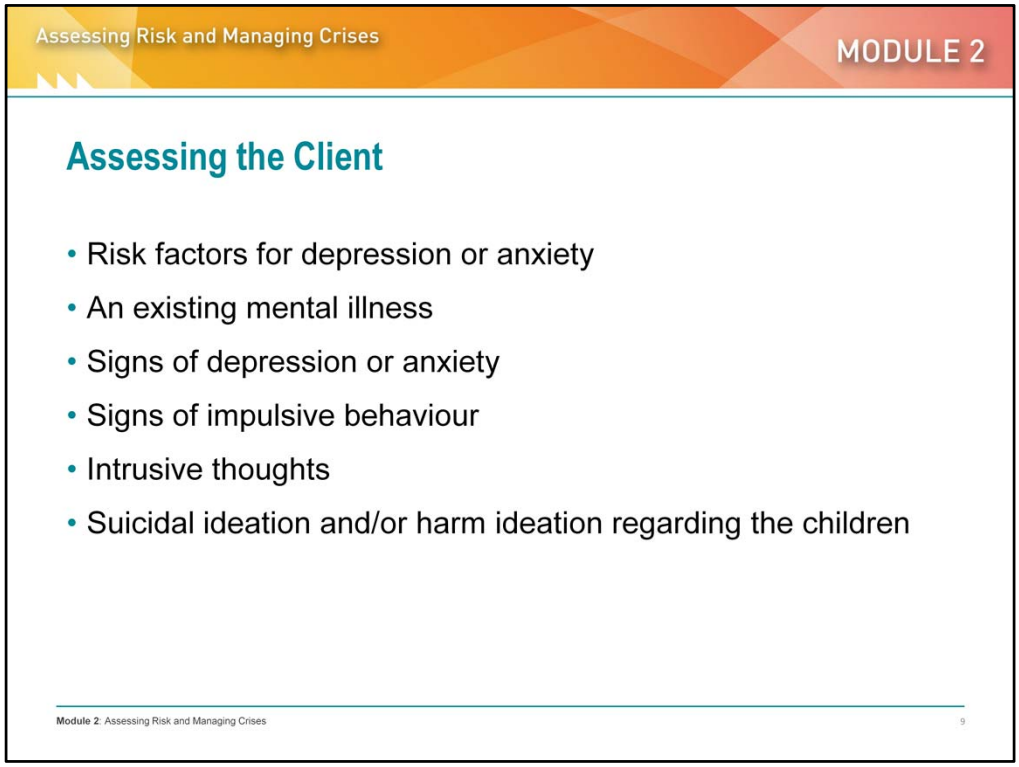
Questions for Reflection (1-4)

What would your immediate response be?

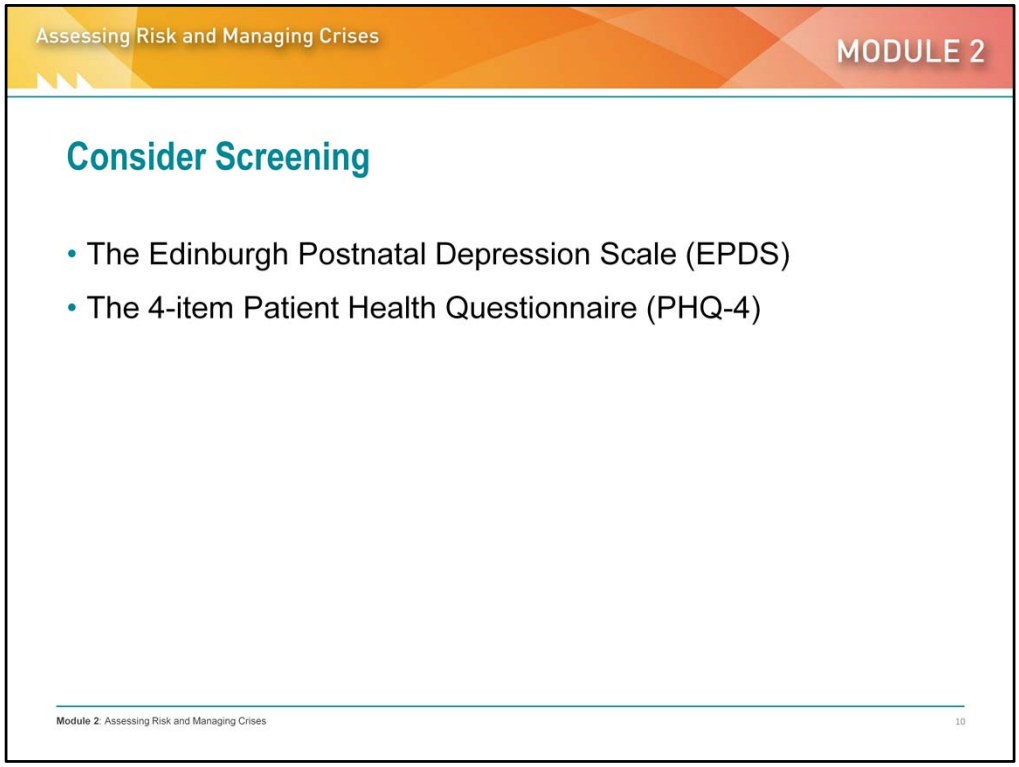
How would you assess Lila's emotional state?

How would you determine what the next steps should be?

Do you routinely ask your clients about self-harm or suicide?



1. Does the client have risk factors for developing depression or anxiety? The following are some key risk factors. For a more complete list, check the resources and references [CAMH, 2005]
    - History of depression, anxiety or other mental illness
    - Poor social supports
    - Stress (e.g., relationship, work)
    - Family violence or maltreatment
2. Does the client have an existing mental illness?
3. Does the client report worrying, anxiousness, feeling down or depressed, having loss of interest in usual activities?
4. Is the client showing signs of impulsive behaviour?
    - Swift actions without forethought; e.g., yelling, throwing things, hitting, self-harm
    - Risk taking behaviour; e.g., driving too fast, spending spree, abuse of alcohol or drugs
    - Not focusing on the task at hand, not planning or thinking carefully
5. Does the client report having intrusive thoughts?
6. Does the client report or show any signs of suicidal ideation or harm ideation regarding the children?



Consider screening the client using:

The Edinburgh Postnatal Depression Scale [EPDS].

- If the client scores over 12 or item 10 is positive ask for permission to contact their/a health care provider.
- Check the RNAO Best Practice Guideline for Postpartum Depression for different cut-off scores when using the EPDS with different ethnic groups.

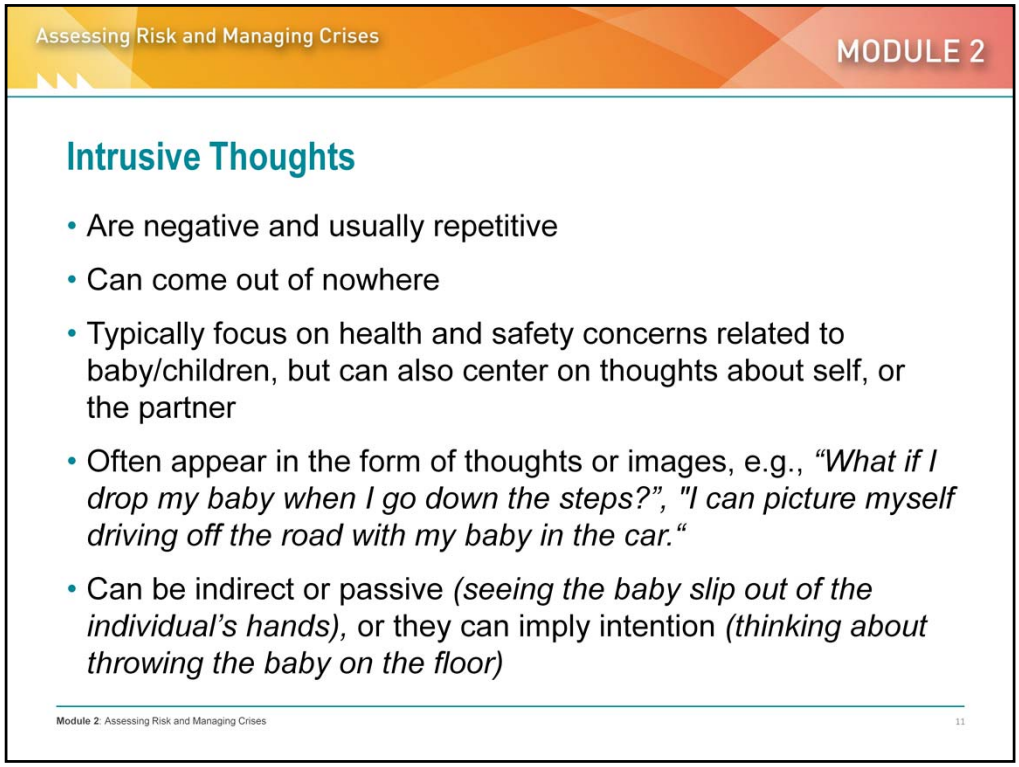
The 4-item Patient Health Questionnaire [PHQ-4] for Anxiety & Depression

- If the client scores in the moderate-severe range (e.g., greater than 5 out of 12) and/or is positive for thoughts of self-harm ask for permission to contact their/a service provider.
- The PHQ-4 is known in most primary care settings and can be used unrelated to the perinatal period.

With consent, fax the screen to their healthcare provider.

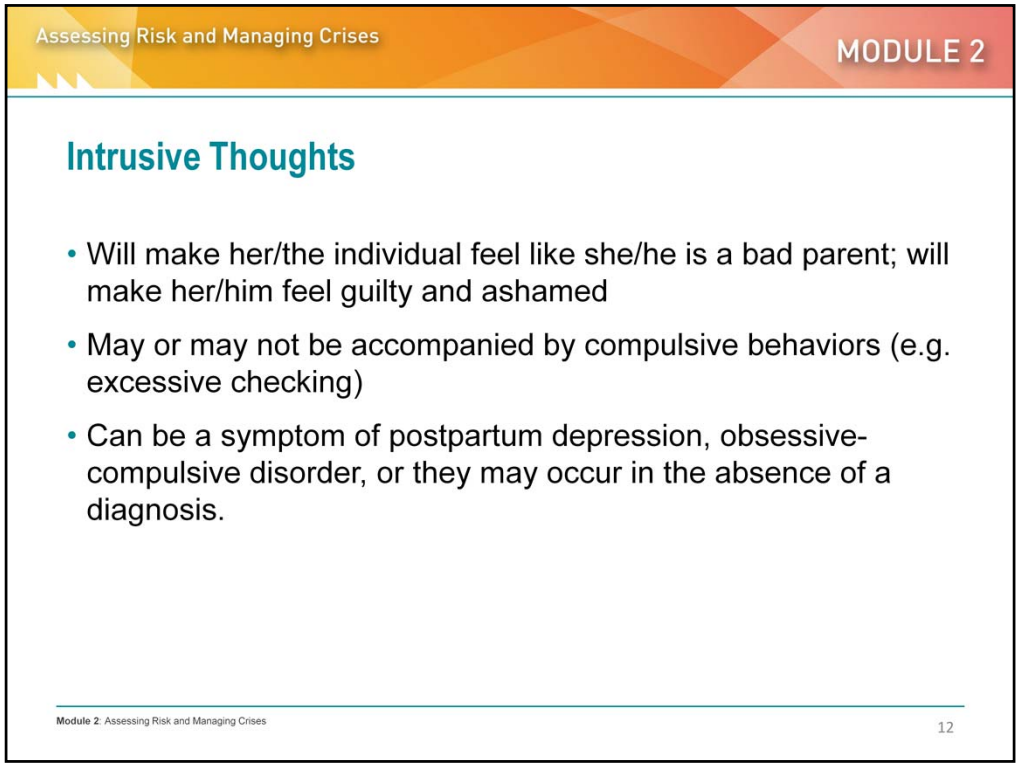
Always rely on your personal judgement or impression as well.

Facilitator discuss use of *EPDS* and *PHQ-4* from handout.



Intrusive thoughts often focus on checking and cause checking behaviours: *"Is my baby's diaper wet again? What if she gets a rash? I will need to check her diaper and change it right away."*

Facilitator: What other thoughts or compulsive behaviours have participants experienced?



Intrusive thoughts are unwanted, frequently scary thoughts that can bombard an individual at any time. Intrusive thoughts can occur in up to 65% of parents (either parent) – most frequently in the 8th month of pregnancy up to birth and during the first three months postpartum (Lechman et al, 1999). They can be an indicator of the development or exacerbation of obsessive-compulsive symptoms. They often cause significant personal distress and interfere with individual and family functioning and have a modest relationship with depressive symptoms (Abramowitz, Schwartz, & Moore, 2003; Fairbrother & Abramowitz, 2006).

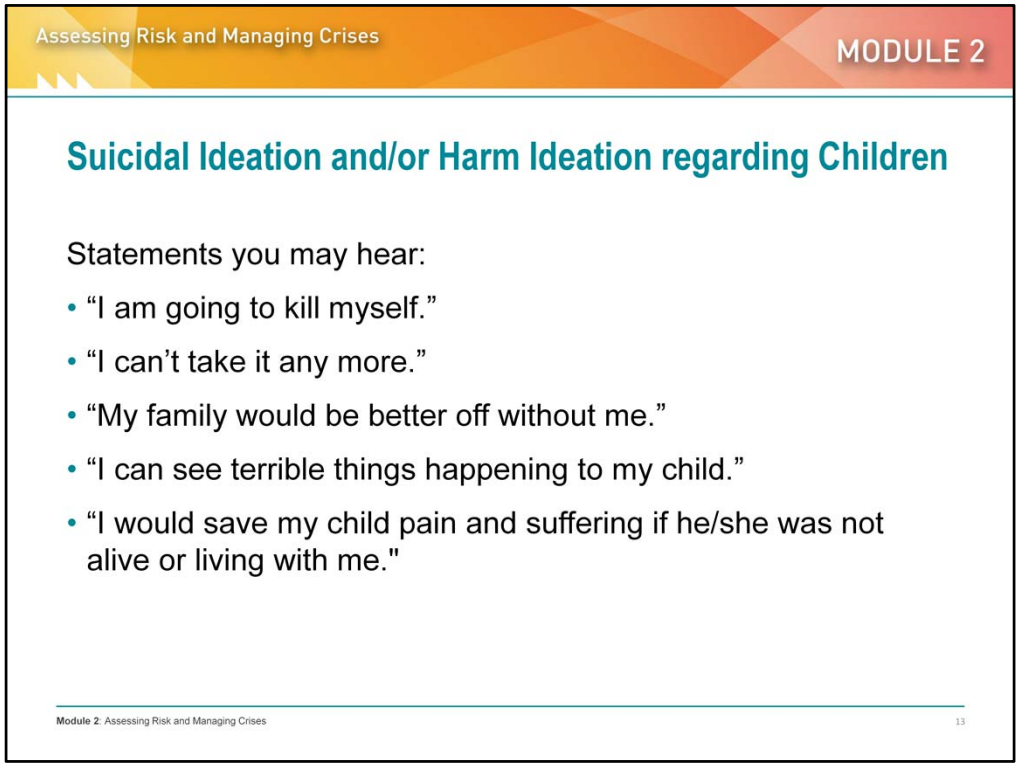
Talking about intrusive thoughts often results in relief and a realization that other parents experience similar

thoughts.

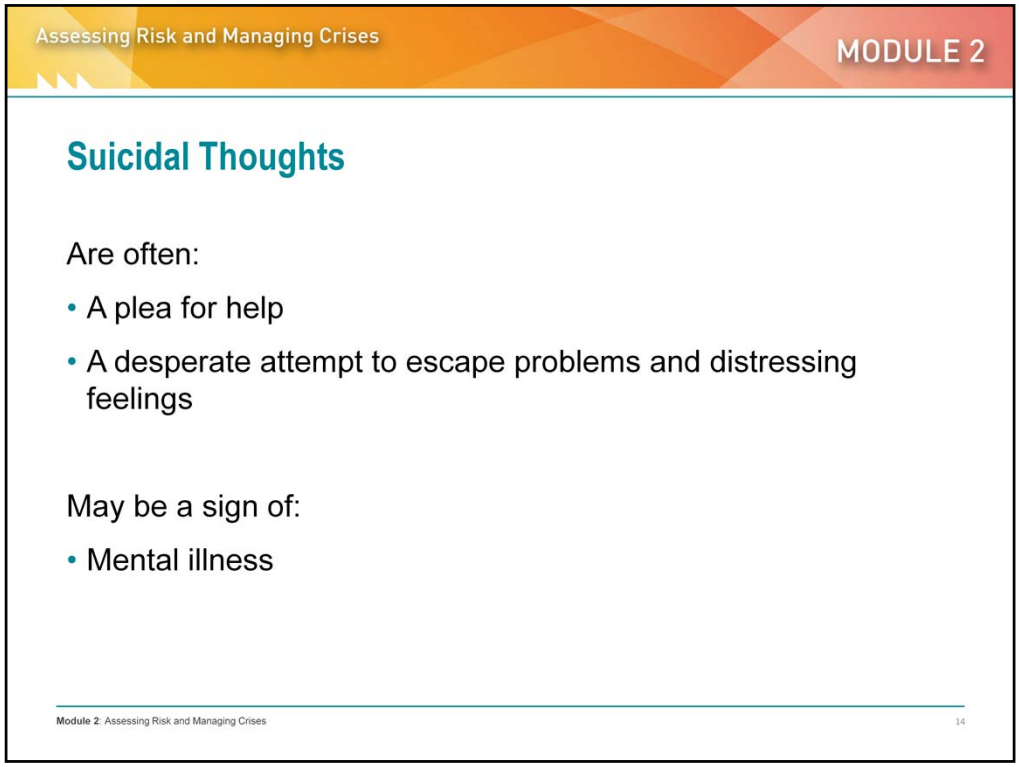
Facilitator use *Questions for Reflection (5 and 6)*

Do you routinely ask clients about intrusive thoughts?

How have you responded to a client telling you they are having intrusive thoughts?



Take seriously all statements made by the client that indicate, *directly* or *indirectly* a wish to die by suicide and all available information that indicate a parent may be at risk for self-harm, harm to others, or suicide:

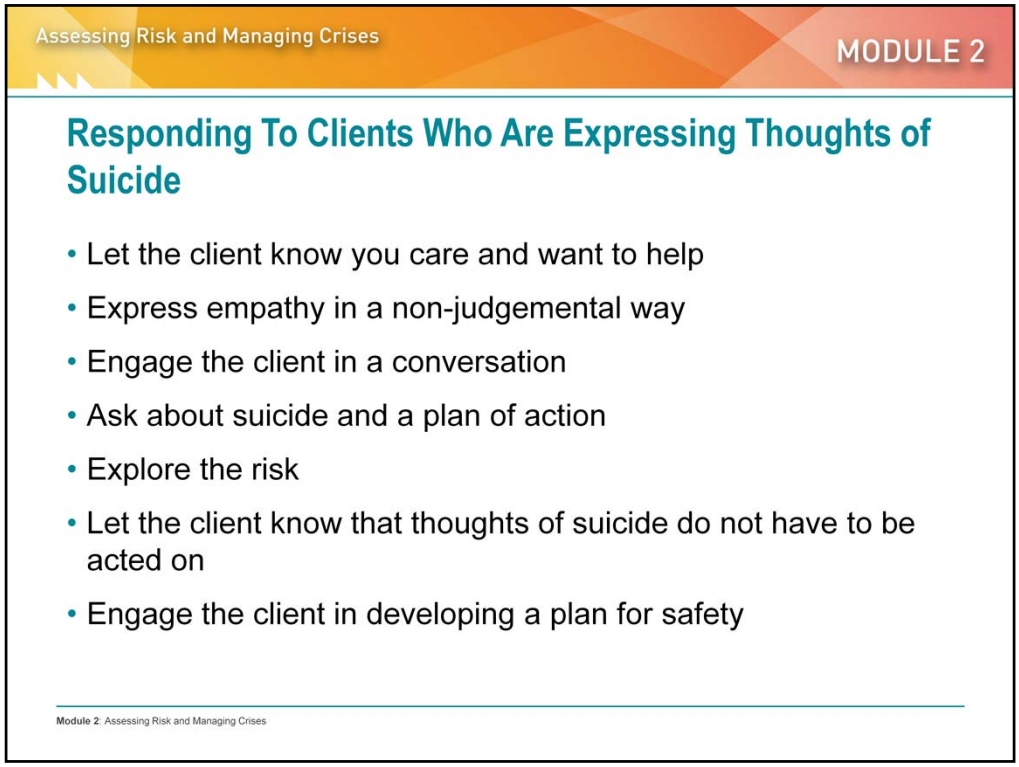


Suicidal thoughts are often a plea for help and a desperate attempt to escape from problems and distressing feelings.

- Talking about suicide is one way for a person to indicate just how badly they are feeling.
- Suicidal ideation and behaviour is sometimes, but not always linked to mental illness.
- **Always take suicidal thoughts as an invitation for help.**

Facilitator use *Question for Reflection* (7)

What other information might indicate that the client may be at risk for suicide?



It is important to:

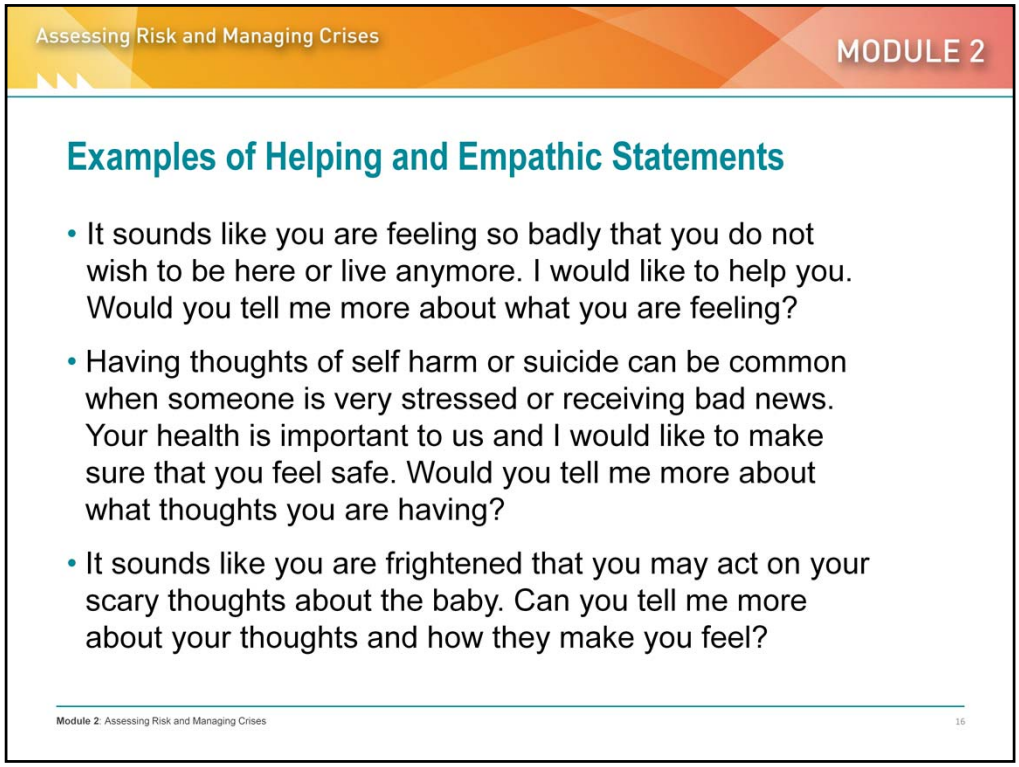
Tell the individual that you care and that you want to help them.

Express empathy for the person and what they are going through.

- Each individual is unique, and it is important to tailor your support to that person's needs.
- Use non-blaming, non-judgmental approach.

Encourage the suicidal person to do most of the talking, if they are able to. It may be helpful to talk about the specific problem the person is experiencing. Specifically, ask about suicide and explore if the client is at risk for action.

Tell the person that thoughts of suicide are common and do not have to be acted on. Then engage the client in developing a plan for safety.



Facilitator ask participants if they would share one of their own examples of an empathic statement.

Explore…

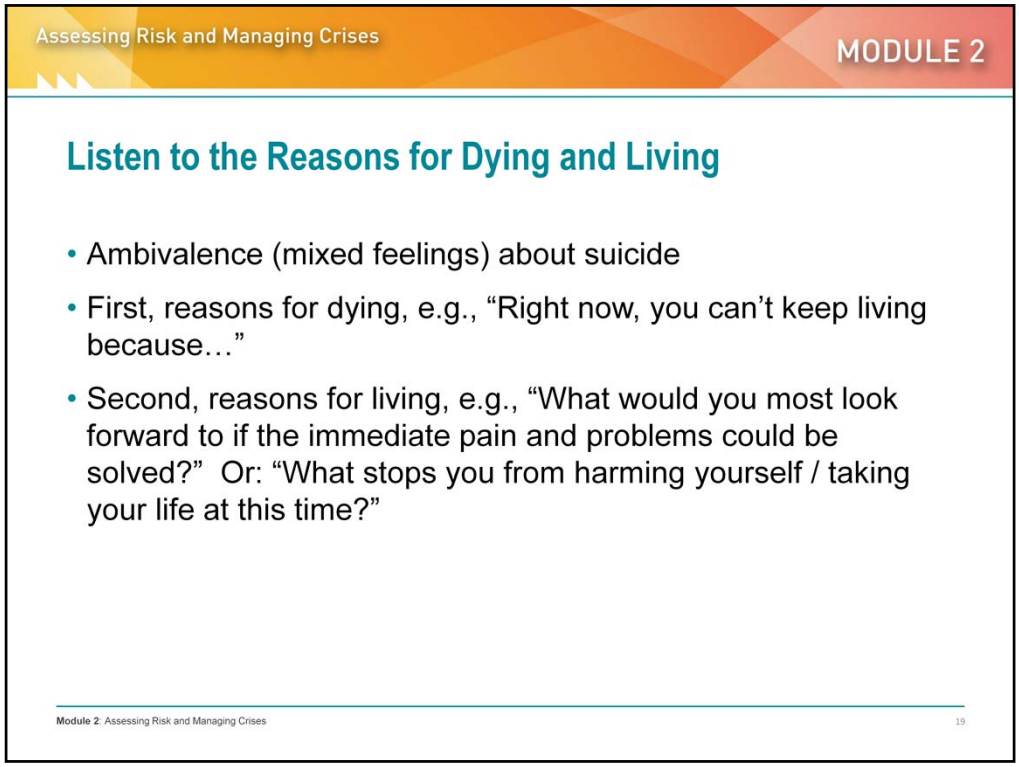
If the client responds **yes** to having (direct or indirect) thoughts of self-harm or suicide, ask for more information:

- Have you thought of doing it?
- Have you decided **how** you would do it?
- Have you decided **when** you would do it?
- Have you taken any steps to get the things you would need to carry out your plan?
- Are you currently using alcohol or drugs (prescribed medications or recreational drugs like pot)?

Explore ….

If the client responds no to having thoughts of self-harm or suicide, ask:

- Do you wish you were dead?
- When you go to sleep, do you often wish you would not wake up?
- Are you doing anything that might result in your harming yourself or dying (e.g., smoking more, binge drinking)
- Are you not doing things that you would normally do to protect yourself from harming yourself or dying (e.g., not wearing a seatbelt, having unprotected sex)
- Have you harmed yourself now or in the past (e.g., cut, burned)

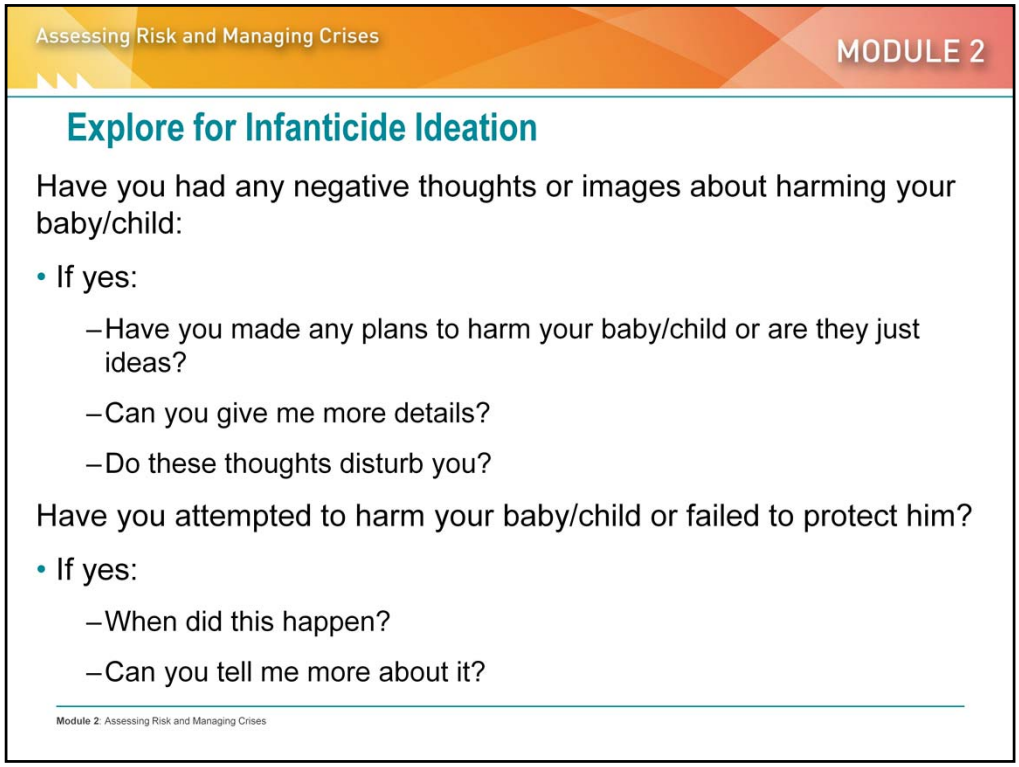


Facilitator ensure participants know to document all answers.
Use *Questions for Reflection* (8-10)

Have you had any experience with a client wanting to harm themself? Have you had any experience with a client having thoughts about harming their child/ren?

What is your internal reaction to suicidal statements? Ideation about harm to others? How have you responded to clients in similar situations?

What other questions can you use to get the client to talk about reasons for dying and living?



If the client:

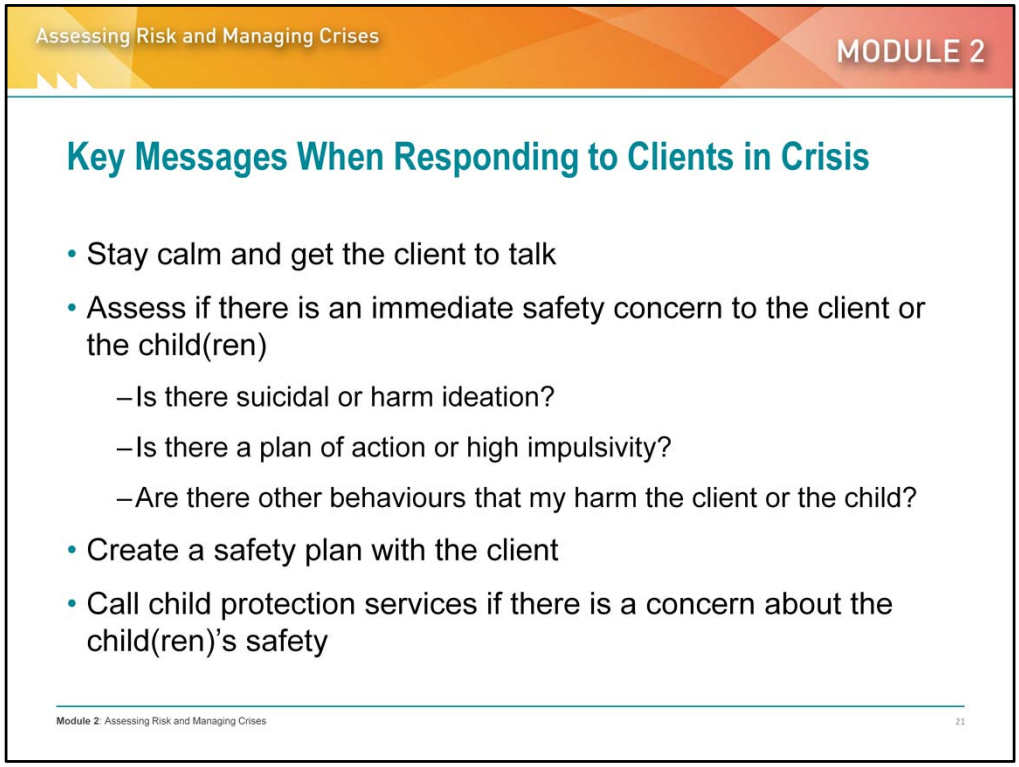
- Knows these thoughts or images are ideas only and
- Is clear about not acting on these

Provide support and **refer to her health care provider** – mark it **URGENT**.

If there is any question about the safety of the child(ren), **involve child protection services** for an assessment, while also providing support and referral to the client.

Facilitator use *Questions for Reflection* (11)

Have you been in situations where there was a risk to a child's safety? How did you respond? What was the outcome?

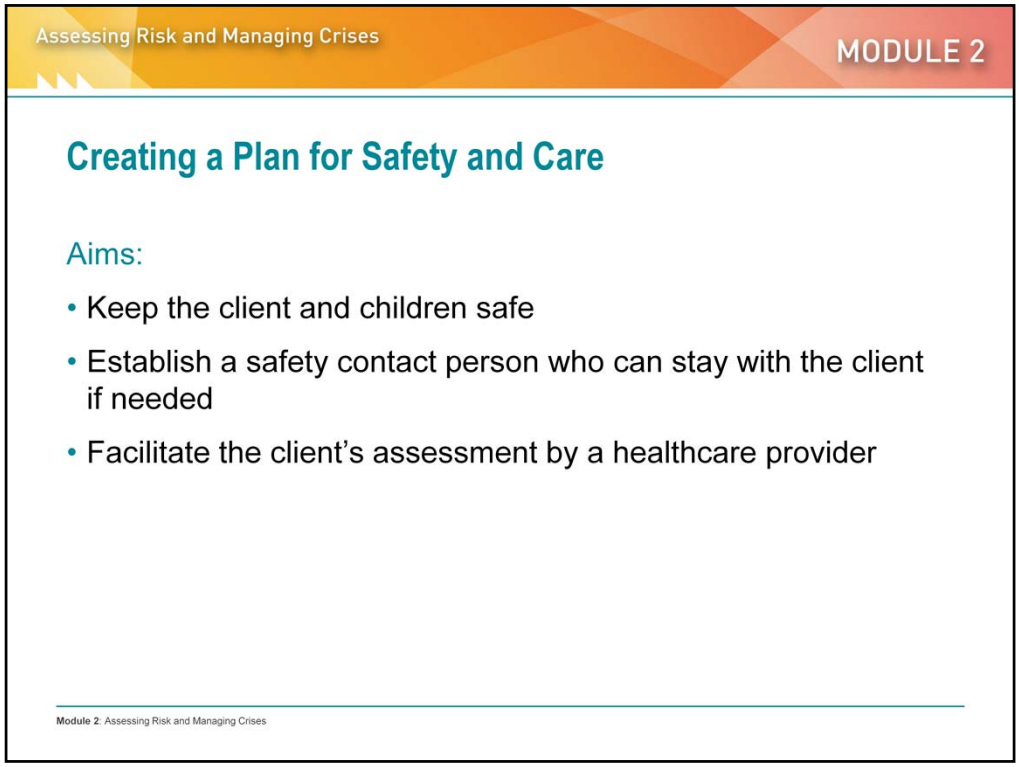


Some of the information from the previous slides was taken from the following references:

Mental Health First Aid (200, 2nd ed) Betty Kitchener & Anthony Jorm (2006). Alberta Mental Health Board as adapted with permission from Australia's Mental Health First Aid and Scotland's Mental Health First Aid.

British Columbia Reproductive Care Program Guidelines for Perinatal Care (2003). Identification and Assessment of Reproductive Mental Illness during the Preconception and the Perinatal Periods. Retrieved on 2012-07-31 from

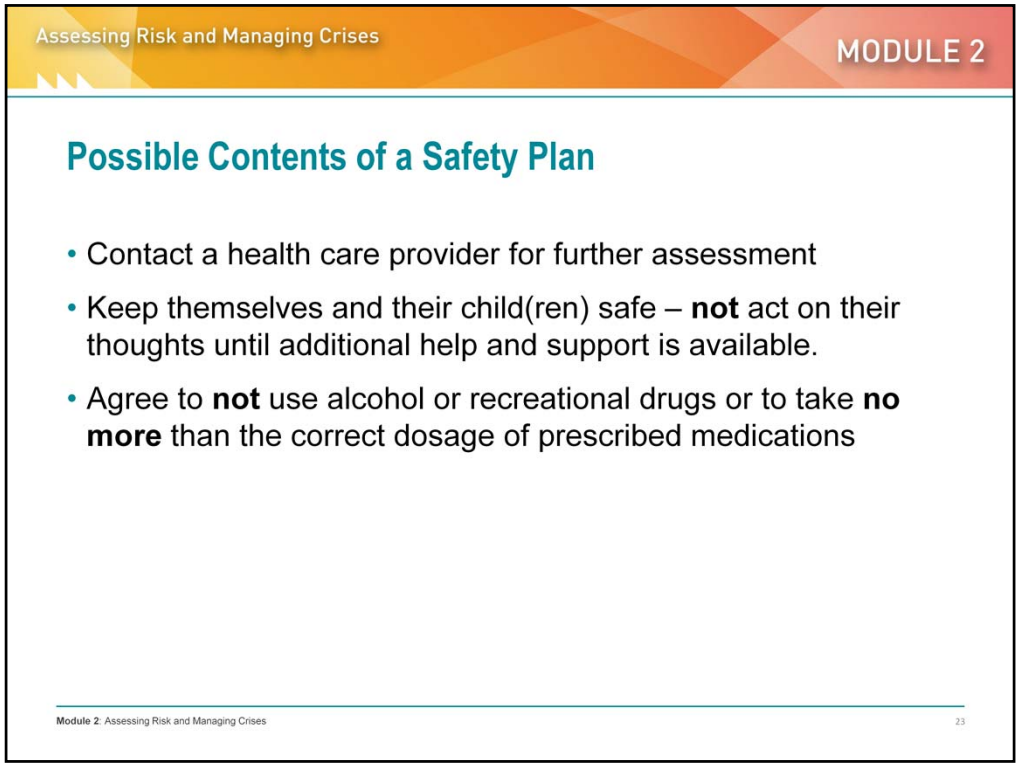
http://www.perinatalservicesbc.ca/NR/rdonlyres/52571845-20C7-4D80-8AF6-6D6BF9FA9C6F/0/MHGuidelinesIdentificationandAssessment3.pdf



Goals of a Safety Plan:

- **Keep the client and children safe.**
- **Establish a contact person who can stay with the client if needed.**
- **Facilitate the client's assessment by a healthcare provider.**

A safety plan is when you and the person at risk agree to a plan that prevents the immediate risk of harm to self or infant/children. A safety plan is specific, has a realistic timeframe, and the client is able to commit to it. E.g., *"I would like to make a plan with you to help you to feel safe and secure. Would you help me with this?"*



For example, in a safety plan the client will agree to:

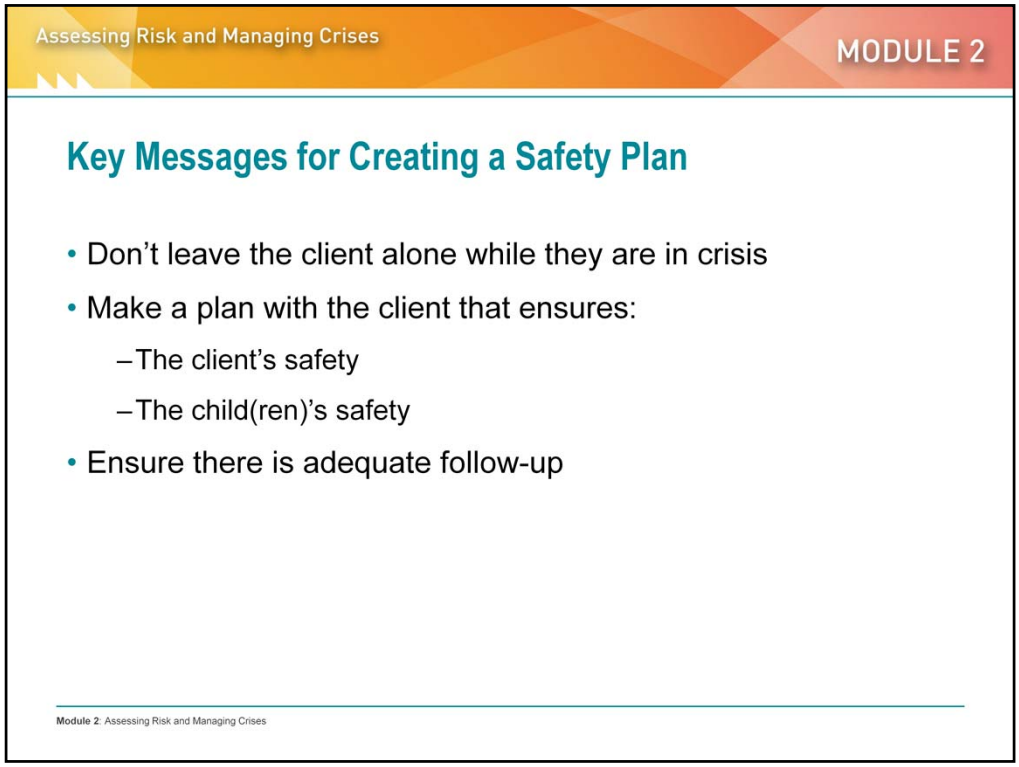
Keep themselves and their children safe – NOT act on their thoughts - until additional help and support are available. E.g., if a parent has thoughts of drowning a baby, a safety plan would include giving the baby a bath only when another person is there to assist.

Agree to NOT use alcohol or recreational drugs, or to take NO more than the correct dosage of their prescribed medications.

Facilitator discuss *Creating a Safety Plan* from handout.
***Questions for Reflection* (12 and 13):**

Have you ever made a safety plan with a client? What did it include?

What other things could be included in a safety plan?



Don't leave the person alone while they are in crisis. A family member, a friend or a service provider can stay with her/him until they have been assessed by a health care provider. If there is no one who can safely care for the child(ren), child protection services can provide support and resources.

Help to arrange transport to the closest emergency room for further assessment.

Facilitator discuss *Resources and References* from handout.

Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre Health Nexus

www.beststart.org and www.healthnexus.ca

This ready-to-use workshop has been prepared with funds provided by the Government of Ontario. The information herein reflects the views of the authors and is not officially endorsed by the Government of Ontario. The resources and programs cited throughout the workshop are not necessarily endorsed by the Best Start Resource Centre or the Government of Ontario.

December 2012