HELP & SHELTER

TRAINING & CAPACITY BUILDING TO ENHANCE SERVICE DELIVERY PROJECT (FUNDED BY THE USAID GOVERNANCE ENHANCEMENT PROJECT BY AGREEMENT WITH PROJECT IMPLEMENTER TETRA TECH ARD)

ARD Activity Report - Training Workshop on Suicide (28 July 2011)

1. Introduction/ Background

This workshop was planned with the aim of upgrading the knowledge base and improving the skills of counsellors, key staff members and volunteers at Help & Shelter and partner NGOs in addressing the issue of suicide. Suicide continues to be problem affecting Guyanese society with an average of approximately 100 deaths yearly between the years 2003-2008. Recognizing that some of the main causes of suicide coincide with problems affecting many clients accessing the services of Help & Shelter and other partner NGO it is indeed timely and important that such a workshop be held. It is hoped that further networking and collaboration with the Ministry of Health's Mental Health Unit, who facilitated this workshop, will go a long way towards a deeper understanding of factors and indicators leading to suicide and more importantly its prevention.

2. Methodology

The methodologies used was a combination of power point slide presentation and group discussions. The session was participatory and interactive

3. Topics and Participant Feedback

The main focus areas were:

Role of gatekeeper

A gatekeeper was described as an adult:

- Who has close contact or who may come into contact with someone who is suicidal
- Volunteer who is trained to help someone who is suicidal
- Professionals such as doctors, police social workers who often come into contact with suicidal persons
- Friends and relatives of suicidal persons

Once you come into contact with a suicidal person the recommendations were:

- You assure and encourage the person to get the help they need
- It is the responsibility of gatekeepers to help suicidal persons and not ask them if they want help
- identify early signs of suicide risk and ask questions to find about suicidal thought
- If needed accompany the suicidal person to get help
- Listen, give comfort and whatever help you can
- Establish a helping relationship as necessary, stay in contact with person, refer and or accompany suicidal person to get professional help

It was pointed out that suicide is not restricted to any one ethnic group but it is known that East Indians in Guyana are more prone to suicide. More recently suicides of persons of African descent in the Linden have increased as have suicide among Amerindians. Participants were advised that when talking to person who may have attempted suicide it is important to find out who is the person who is closest to them. Suicidal persons can feel isolated and lack social support and may find it difficult to ask for help. Many people often fail to recognize the signs of suicide as a result suicidal persons may not get the help they need from their families that is why it is important to train people to identify and react to prevent suicides. It was advised that once you have noticed a person having suicidal thoughts or sign you can talk to them to find out if everything is okay.

Activity

Participants were asked their immediate thought to 2 scenarios

1. Daughter of a politician shoots herself in the chest
2. Teen found hanging from a tamarind tree in uncle's backyard

Participants' responses to first scenario included; the daughter had issues because there was no love in the home; it was due to neglect and a cry for attention; boyfriend and girlfriend story; pressure from school mates who brand her father a messed up politician; dau8ghter feels pressured because she does not get the freedom she wants to go places; she did something bad and it will reflect on her father's position.

Participants' responses to second scenario included; the teenager lost both his parents and felt neglected; teen experimented; mental illness or a disorder suffered by teen (most time they are in their own world and withdrawn).

Values & Beliefs

Values were described as internal beliefs that we have moulded within us. Beliefs on the other hand are influenced by our culture and are things we put into practice. Beliefs can influence our thinking and person can be influenced by others however you have the final decision. Participants were advised not to impose their value system on the other person, instead to use their influence to help them. Gatekeepers need to be aware of their values and beliefs and understand the impact these have on reactions to others.

Myths & Reality

Myths were described as statements which are false! Some examples of myths are: if you come in late with a baby you must come in by the back; put a manicole broom over your door; if you are HIV positive and have sex with a virgin you can be healed.
Reality on the other hand is a fact, (things that are true)!
Some statements on suicide were given and participants were asked to comment on if they were myth or reality.

Risk Factors

It was pointed out that suicidal behaviour is not a disease but a complex interaction of psychological, cultural and social factors. These factors are:

- Pre-disposition factors e.g. suicidal history, history of abuse and violence, experiences of loss while very young, isolation, lack of significant relationships, trivializing suicide, psychiatric disorders, depression, previous suicidal attempts, non-resolved grief issues
- Contributing factors e.g. substance abuse of all kinds, lack of coping abilities, instability in the family, lack of resources
- Precipitating factors or triggers of a crisis e.g. failure, humiliation, rejection, broken heart, divorce, disciplinary crisis or other recent and difficult life events
- Protection factors which reduce the impact of contributing and pre-disposition factors e.g. health role models, availability of nearby accessible resources, good social and coping skills etc, family and social support

Group activity

Participants paired off and were asked to think of some unimportant thing to complain of and then find the positives in the complaint.

Indicators of Suicide Risk

- Direct verbal messages: "I want to be done with this life"; "I'll kill myself"
- Indirect verbal messages: Talks about death, being "fed up"; "Life isn't worth it"; You'd be much better without me"; talks about writing their will or of a long tem departure or trip they are planning, or gives unusual signs of affection " don't ever forget that….."
- Behaviours: isolation, withdrawn, sudden interest in firearms, medications, giving away prized belongings, abuse of alcohol/drugs/medications, sudden outburst of emotion, hyperactivity or lack of energy, incoherent speech

- Psychological symptoms" inability to enjoy anything, memory loss, sadness, boredom, irritability, significant decrease in self esteem
- Biological symptoms: sleep disorders, eating disorders, stress symptoms

Participants were advised that the only way to really know if a person is thinking about committing suicide is to ask him/her directly.

Suicide Risk Assessment

In assessing risk there are 3 levels of urgency which needs to be determined so appropriate action can be taken:

1. Low Urgency: Person has suicidal thoughts but no plans
2. Medium Urgency: person has not decided on the how where and when as yet or when is over 18 hours from now
3. High Urgency: Knows how, when, where and it is within 18 hrs; an attempt is in progress

Group Exercises to determine accurately the client's suicide risk urgency using a series of different case scenarios were done with participants

Suicidal Stages

- Ideation: the suicidal idea surfaces at this stage the part that wants to die is equal to the part that wants to live; persons fears their suicidal ideas; idea of suicide continues to surface person starts withdrawing
- Rumination; decrease in solutions to the problem, anxiety increases, situation begins to feel unbearable; thoughts of suicide surface several times a day; increased loss of self esteem, withdrawal and isolation increases
- Crystallization: anxiety increases dramatically, situation becomes unbearable, person is ready to do anything to stop the suffering, suicide is perceived as the only exit door, plan is formulated, has everything prepared, can rationalize the suicide, may not want help
- Act in Progress: the person has attempted the suicide
- Don't fall into the trap of not asking direct questions about suicide either from fear or feelings that question will be insulting, don't create the answer by asking negative questions such as "You are not thinking about killing yourself?"

Crisis Intervention

First ensure the safety of the person that is in immediate danger, intervene in such a way so that the person can or has the ability to take action to resolve the immediate danger to him/her. Keep in mind the following:

- Intervention must be active and one which allows the person to regain control of his/her situation
- Intervention must be specific and concrete
- Intervention must promote the return to emotional stability/equilibrium
- Intervention must create doubts and revive hope. To bring back hope means to bring the suicidal person to a state of mind of reasonable doubt about suicide and that a change/solution is possible
- Intervention must actively involve the person
- Intervention must provide information
- Intervention must involve the environment including human resources such as support of persons close to the individual- friends, parents

The intervention plan includes:

- Making contact and adjusting oneself to the person's state of mind (find a calm, private place to talk, stay calm, be empathetic, encourage person to express feelings, don't judge or persuade, do not express feeling sorry or pity, believe what you are hearing best solutions come from suicidal person)
- Evaluating the level of danger
- Exploring the main problem, what are the factors involved, perception of person, emotional make up of person

- Reposition the problem – reframe the problem, creating a doubt, assess what the person needs
- Explore options – what is the person prepared to do, what are possible options/resources support network of person
- Action plan – make an agreement what, how, when, who, where

Group Exercises

A group exercise on Normalization was done. Participants were asked to normalize the person's experience and ask about suicide.

The final group exercise done was based on 2 case studies and participants were asked to evaluate the level of suicide risk, what could be done to reduce the risk of suicide and where the persons could be referred to for help.

Evaluation

In evaluating the workshop participants said they learnt that as gatekeepers they can prevent suicide from occurring; the warning signs and graphs on suicide prevalence were eye openers; identifying and sourcing of local resources for additional support for suicidal persons was of great importance; as gatekeepers they have to be very active listeners and really hear what is being said and not want they want to hear; they have to be careful not to impose their values on others; that it is the combination of factors which causes a person to become suicidal and there is usually more than one problem which triggers suicidal thoughts; in counselling suicidal persons it is important to also screen other family members; to listen attentively, look for the signs, assess the stage of urgency the persons may be at and intervene appropriately; suicide can happen at anytime and to anyone and it is up to us to listen to the individual with care and support so as to help him/her through the crisis; persons can be at various stages in the suicidal process and it is essential to be able to identify where they are.

Participants said they learnt about the role of gatekeepers and information on the different stages of suicide. they also learnt about the persons state of equilibrium and the various stages such as state of vulnerability, crisis state, dis-equilibrium and the acute phase; to recognize the pre-disposition factors and how to do an emergency assessment including stages of urgency; risk factors in suicidal persons and the suicidal process; participants also said that the learnt through applying the theory to case studies during the workshop

Recommendations of participants included making the workshop material more gender balanced as men tend to be ashamed to come out and talk about their problems. it was also recommended that there should be more programmes for families on preventative measures for suicide, there was a need for more professionals such as psychologists to work in this area and for counsellors to work in schools; it was also felt that the increase in substance abuse in communities need to be addressed as this can be a factor in attempts of suicide. Every year there should be a national gatekeepers' conference held in each region for feedback and sharing of information and new initiatives; it was recommended that a there be additional family suicidal support group set up for families who have lost a member(s) due to suicide, presently there is only one such group operating at the Georgetown Hospital.; there was a need for hotline services to be available for all regions in Guyana; the need for a public education programme to be implemented in all schools.

The facilitators from the Ministry of Health shared that the Ministry is embarking on making safety boxes to store poisonous substances such as fertilizers, pesticides and other poisonous agricultural products used by farmers etc in which only one person can have access to the box so as to reduce attempts and risk of suicide.

4. Follow-up sessions

No follow up session was planned on the topic of suicide

5. Qualitative reporting Techniques

Qualitative information was gathered through the use of group discussions and participant feedback, group evaluation reports and open ended questions on the H&S participant evaluation forms. Forms were anonymous so opinions expressed could not be traced to any one individual.

6. Quantitative Reporting Techniques/Methodologies

Quantitative information was gathered through the use of tools such as:

- ARD required attendance sheets
- Participant evaluation forms developed by Help & Shelter which assessed quantitative information on delivery and grasp of information

As participants arrived they were directed to fill out required information on the attendance sheet. H&S participant evaluation forms were given out and participants were asked to fill out and return to the M&E officer at the end of the workshop.