SPOT

SUICIDE PREVENTION, OUTREACH AND THERAPEUTIC SERVICES

About VSM

"A local NGO, part of Victim Support Europe established to care for, contain, support and empower all victims of any crime.
With a firm belief in the power of human resilience we passionately champion the rights of victims in Malta.
Our love for the service we provide is only paralleled by the determination, devotion and respect we offer our clients.
VSM strives to consistently positively contribute to the lives of regular people who experience extraordinary events.
Our principle objective is to empower and regenerate victims of crime to a healthy and self-sufficient state of well-being".

Generic Services

Provision of emotional support and legal information to all victims of all crime.

Services include:
- *Psychotherapy and counselling*
- *Court accompaniment*
- *Information pertaining to rights and legal procedures*
- *Application for criminal injuries compensation scheme*

Statistics:

Year	Number of Cases
2015	59
2015	80
2017	87
2018	96

Care for Victims of Sexual Assault

- *Provision of psychotherapeutic services to victims of sexual assault and rape*
- *Provision of psychotherapeutic services to families of victims of sexual assault and rape*
- *Provision of psychological assessments to victims of sexual assault and rape*
- *Provision of full legal services pane civile to victims of sexual assault and rape*
- *Liaison with police, hospital and GU clinic*
- *Advocacy pertaining to rights and legal procedures for victims of sexual assault and rape*

Statistics:

Year	Number of Cases
2015	34
2016	35
2017	23
2018	27
2019 to date	29

Developing SPOT - Desk Research

Local (Bonnici, 2007)

289 suicides have occured on our island between 2007 and 2017

255 of those individuals were males

On average, 29 families per year, have lost a loved one to suicide over the past 10 years

International

A family history of suicidal behaviour increases risk of suicide, independently of psychopathology (Powell, Geddes, Gallaze, Hawton, 2003; Mann, Waternaux, Haas, Malone, 1999)

Previous suicide attempt is a high predictor of completed suicide, especially amongst females (Brent, Baugher, Bridge, Chen, Chiappetta, 1999)

Each suicide impacts 6 – 20 people (Cerrone, Visser, & Scuffham 2013)

Proposal - Training

Pete's Dragon

Safe Talk - training about suicide
ASIST - assessment and safety planning
Bereavement and loss
The specifics of suicide bereavement
Facilitating peer support groups
Wellness and recovery from suicide – action planning

Proposal - Pilot Service

Target client group (24 per year based on local statistics)
- *Persons bereaved by suicide (8+)*
- *Persons with a previous suicide attempt (8+)*

Service provision
- *SLO service*
- *Individual Therapy*
- *Family Therapy**
- *Group Therapy*
- *Psychiatric Services*
- *Psychological assessment*

*Family therapy services is also available to clients with children, as long as the family members have care and custody of the children

Current Situation: February 2019 - May 2019

Number of individuals accessing SLO services	*9*
Number of individuals accessing individual psychotherapy	*6*
Number of individuals / families accessing family therapy	*3/1*
Number of individuals accessing psychiatric services	*4*
Total number of individuals supported	***17***

Training

Of the myriad training opportunities we explored through desktop research, we were drawn to ***Pete's Dragons.*** *Exmouth, UK) moved by the personal experience that launched a hugely successful Charity aimed at* ***supporting those bereaved by suicide*** *as well as* ***training the trainer*** *programmes.*

Alicia Jordan
Clinical Team Magner

PETE'S DRAGONS *Comfort after suicide loss*

The 5 day intensive training we received went well beyond our expectations to be trained in TALK and ASSIST. A crash course in setting up a ***holistic service*** *including* ***first hand experience*** *of being bereaved by suicide,* ***setting up and supporting the team*** *who provides the service, roles, financials, reporting, legal frameworks.*

Best of all, we returned ***INSPIRED*** *and* ***ENERGIZED.***

Building Blocks

On our return and together as a close knit team we...
Step 1:
Wrote out the service. Established Standard Operating procedures outlining how the service would operate including Roles, procedures, referral forms and treatment planning.

These SOPs are a living document and continue to be built as the service evolves.

Building Blocks - cont.

Step 2:
Set up meetings with relevant entities and individuals to
- *Gather information*
- *Advise about our upcoming service and*
- *Establish a clear referral procedure.*

Meetings were set with Richmond Foundation, Victim Support Unit (police), Dr Anton Grech, The Crisis team at Mt. Carmel (Dr Taylor East, Dr. Zahra and Dr. Micallef Trigonat, Mr. Spiteri chairperson of A&E at Mater Dei as well as less formal ongoing networking with Appogg and health care professionals working in the private sector.

Introducing the service through our roles

As USM's **Executive Chairperson** and **Clinical Supervisor**, with clients' best interest at heart, my first point of concern launching this project was maintaining the safety and stability of our team.

In order to prevent the front-liners becoming overwhelmed we set up the following standardised support:

1. Fortnightly team meetings – admin agenda
2. Fortnightly clinical group supervision for SLO, (family therapist, clinical psychologist, counsellor and psychotherapist)
3. Unscheduled individual clinical supervision on demand and as needs arise in line with clients' crises

Flat Hierarchy

Our small Spot team relies on a flat hierarchy where roles and accountabilities are clear and equally necessary. This is a chain that relies on all roles being active and efficient.

The supervisory role ensures that the front-liners are coping well and continuing to be effective in their support of our clients.

The whole is greater than the sum of its parts

PHILOSOPHY

We will never know enough.
What we don't know – we ask.
We are happy to collaborate.
We can only do this together.
Clear boundaries.
Multi-disciplinary approach both internally and over-arching to other ends.
We exist to serve the community.
We feel privileged to be part of positive growth.

Suicide Liason Officer

We like to think of this role as a cross between Social work and basic counselling.

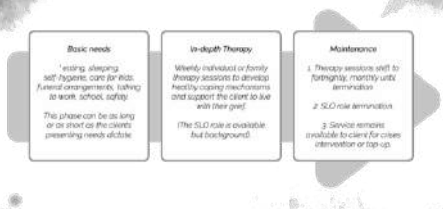
*The role relies loosely on the base of **Maslow's Hierarchy of Needs** where the primary goal is to ensure that the client's basic needs are met.*

This role is currently filled by two people who by professional are Psychotherapist and Counsellor. Negotiating the shift in boundaries has been interesting. On the one hand it feels liberating to be able to physically talk... make a call, set an appointment, cook a meal... On the other hand, stopping myself from shifting into talking issues out on a deeper level – tricky.

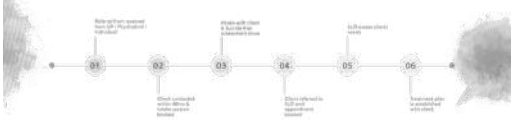
*The SLO role falls within the first **phase of contact** and relies solely on supporting the client to attend to their own basic needs. The goal of this phase it to support the client to develop gradual self-reliance and be ably to again stand on their own two feet.*

Maslow Adapted

Phases of SPOT Service...



SPOT Referral Pathway



Treatment Plan

It encompasses the unique situation of the individual and supports them in management of their primary needs. It also serves as a platform to enable and encourage them to reach their goals in a supportive and timely manner.

Using a treatment plan supports both the SLO and client to work towards concrete goals, experience and observe progress or attend to regress.

This is a tool that provides structure amidst the chaos.

Some of our stories at SLO Phase

Case 1

Janet is a middle aged bereaved mother who lost her son to suicide. There is no one left in her nuclear family and she does not experience her family of origin as supportive. She was referred to SPOT by the mental health services.

Janet is taken on by a Suicide Liaison Officer, Post Traumatic Stress Disorder symptoms prevalent including suicidal ideation and refusing to eat.

*SLO met with Janet **daily** at our VSH site in Ascot. He formulated a basic **plan** with her, obtained **medical** and **psychiatric appointments** with her, roped in her **family** who was referred to our Family **therapist** for **support**.*

*When Janet presented a more **concrete suicide plan** she was **accompanied** by her SLO to hospital by **Ambulance**. Her SLO visited her daily, provided she agreed to eat. She was subsequently diagnosed with Narcolepsy and PTSD and medicated accordingly. Janet was referred to Mt. Crome, however on insistance she was **released** in the care of family.*

Janet is currently being seen twice weekly and working towards meeting goals on her treatment plan including managing her affairs, self-care and managing her connections with people. She is not currently stable enough to start in-depth psychotherapy.

Some of our stories at SLO Phase

Case 2

*Sarah was a **self-referral** to VSH and referred to SPOT SLO services following intake.*

*Sarah reported symptoms related to **PTSD** triggered by a severely traumatic experience related to **Domestic Violence**. Sarah had an attempt at **suicide** 3 years prior.*

*Unable to work due to **trauma**. Sarah was experiencing **financial** crisis; she was suffering from physical health problems that had not been attended to. Sarah was unable to cope with living issues due to vulnerable mental state.*

Often unable to get out of bed and care for herself, the wellbeing of Sarah's children was of growing concern.

*SLO and Sarah established **treatment plan** goals relating to mental, physical, financial and parental health.*

Eldest daughter invited to access our services as we were concerned about her wellbeing. A psychiatric referral was made and referred for Psychotherapy.

Some of our stories at SLO Phase

Case 3

Elderly couple who lost their son to suicide self-referred to SPOT.

With only a few SLO sessions under our belt, the couple recognised that they are well supported by their family, close friends and community.

They have chosen to not avail themselves of family or individual psychotherapy and we have agreed on a treatment plan that involves the Suicide Liaison Officer checking in on a fortnightly basis. Following the client's pace in some cases is of the utmost importance. Our goal here is to remind them that we are available and interested – whenever / if ever, they are ready to access more of our services.

Phase 2: Therapeutic Support

Individual Counselling, Individual Psychotherapy, Family/Systemic Therapy/Clinical Supervision

For starters, our services can overlap. Any given client will have come to the end of phase 1 and be referred to more in-depth work with a family and/or individual therapist/counsellor. To that end, a close channel of communication and group supervision help to maintain clear boundaries within the team and for the client.

Currently our greatest asset is the fact that we are a small team of zealous, passionate professionals who dedicate ourselves to the wellbeing of our clients. Our backgrounds vary and include Gestalt, Transcultural, Psychoanalytic and Systemic approaches to client intervention.

The second phase relies on the hope that we can support clients to integrate this new version of themselves, living with 'grief' finding it less over time, shifting from guilt to again embracing life, creating meaning out of their loss, not being defined by their loss.

Our ultimate goal is for our clients to no longer NEED us.


A story from phase 2:
Therapeutic Intervention
Paula was a self-referral. Her brother had completed suicide a couple of years prior.
Following intake, Paula was observed to stable, relatively well adjusted, coping with all accountabilities including family, work etc. It was agreed that Paula would not benefit from SLD role and was therefore referred straight to individual Psychotherapy
Her current therapy attends to issues of
- Grief
- Family dynamics
- Attachment
- Self Care without guilt
- Anger and aggression
SPOT


Thank You