Welcome

NO MORE Suicide Annual Summit

Changing suicidal and self-harm behaviour

Chair: Councillor Gill Neal, St Helens Council

Working together to improve health and wellbeing in Cheshire and Merseyside

6th September 2017
Housekeeping

- Fire exits
- Toilets
- No fire alarms planned
- Phones on silent
- Twitter hashtags #NOMORE, #WSPD17, #TAKEAMINUTECHANGEALIFE
- You can join Thunderclap http://thndr.me/nAp9Z7
Objective for today

The purpose of this year’s summit is to launch the 2017 update to the NO MORE Suicide strategy and learn more about suicidal and self-harm behaviour.
Sue Forster
Director of Public Health, St Helens
Chair of NO MORE Suicide Partnership Board

Working together to improve health and wellbeing in Cheshire and Merseyside
Champs Collaborative Overview

- Champs Public Health Collaborative, established in 2003, is made of many members and partners across Cheshire & Merseyside.
- It has a nationally recognised collective way of working and a strong track record in improving health outcomes.
- Key priorities include tackling high blood pressure, improving mental health and wellbeing, reducing alcohol harm through licensing, supporting strategic partnerships across Liverpool City Region and Cheshire & Warrington and maintaining safe and resilient communities.
- Ensured public health priorities included in the C&M FYFV – alcohol harm, high blood pressure and AMR.
- Led by the eight Local Authority Directors of Public Health and reports to nine Local Authority Chief Executives.
Sue Forster
Director of Public Health, St Helens
Chair of NO MORE Suicide Partnership Board

Working together to improve health and wellbeing in Cheshire and Merseyside
Zero Suicide

The vision

Cheshire and Merseyside is a region where suicides are eliminated, where people do not consider suicide as a solution to the difficulties they face. A region that supports people at a time of personal crisis and builds individual and community resilience for improved lives.
**How can we reach zero?**

Suicides are not inevitable. There are many effective ways in which services, communities, individuals and society as a whole can help to improve mental health and prevent suicides.

The goal of NO MORE Suicide will be achieved by sustaining four outcomes:

<table>
<thead>
<tr>
<th>Letter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Cheshire and Merseyside becomes a Suicide Safer Community</td>
</tr>
<tr>
<td>B</td>
<td>The Health Care System transforms care to eliminate suicides for patients</td>
</tr>
<tr>
<td>C</td>
<td>Support is accessible for those who are exposed to suicide</td>
</tr>
<tr>
<td>D</td>
<td>An integrated Suicide Prevention Network provides oversight and governance</td>
</tr>
</tbody>
</table>
Green shoots since 2015

A NO MORE Suicide Training Framework:
Skills for community, primary care and specialist mental health workforce.
NO MORE Suicide Community Training for ‘community gatekeepers’.
Zero Suicide Alliance e-learning welcome resource for all.

B Safe Care for in-patients; joint action learning approach by three mental health trusts
Mersey Care have gained national recognition for their Zero Suicide Strategy and are founder members of the Zero Suicide Alliance
Street Triage Car in Cheshire and Merseyside with police and mental health practitioner.
Crisis Houses funding and James’ Place Sanctuary

C AMPARO suicide liaison service began April 2015, alleviating distress, risk of clusters, contagion and reduced cost of suicides.
Community Response Plan provides guidance to local groups

D Board multi-agency partnership acting as leaders locally and nationally.
Suicide prevention in Cheshire and Merseyside Five Year Forward View
Suicide Audit Toolkit for systematic data collecting and reporting.
Real Time Surveillance- timely response to ‘suspected suicide’.
Sex
74% of people in the audit were male

Healthcare
Almost half of people in the audit had visited a health service in the month before they died (47%).

By age group, the most common risk factors were:

- Under 25 – Drug misuse (44%)
- 25-44 – Mental health diagnosis (64%)
- 45-59 – Physical health problems (70%)
- 65+ – Physical health problems (92%)
## Focus for Action 2017-2020

| Inequalities | Higher risk in deprived neighbourhoods, impact of welfare reforms, frequency of negative life events |
| Men | ‘Men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas’ |
| **Children & Young People** | Suicide for 15-19 year olds risen for 3 consecutive years since 2013 | Adverse Childhood Experiences can make young people more vulnerable to suicide. Bullying, exam pressures and use of internet on methods of increasing concern. |
| **Self-harm** | 38% of those who died by suicide in Cheshire and Merseyside in 2014 and 2015 had self-harmed/attempted suicide. | Self-harm hospital admissions in Cheshire and Merseyside are significantly worse than the England average |
| **Safer Care** | Almost half of people in the audit had visited a health service in the month before they died (47%) providing an opportunity for intervention. Safer Care in mental health and primary care could significantly reduce suicide rates. |
Actions for outcomes

Long Term Outcome
NO MORE Suicide in Cheshire & Merseyside

Intermediate Outcome 1
Cheshire & Merseyside becomes Suicide Safer Community

Intermediate Outcome 2
The Health Care System transforms care to eliminate suicides for patients

Intermediate Outcome 3
Accessible support for those exposed to suicide

Intermediate Outcome 4
A strong integrated Suicide Prevention Network

LEADERSHIP

Outcome 1
An effective Suicide Prevention Partnership

Outcome 2
Sustained strategic action & resources to create suicide safer communities, achieve and maintain Suicide Safer Community Accreditation

Outcome 3
All 9 local authorities implement suicide prevention plans that meet PHE Guidance

Outcome 4
Strategic partnerships/boards across C&G support suicide prevention

Outcome 5
Signed up to the Zero Suicide Alliance & members of the National Suicide Prevention Alliance

PREVENTION

Outcome 6
Increased awareness of suicide risks and suicide prevention

Outcome 7
Improved mental health, wellness, resilience and recovery

Outcome 8
Improved suicide prevention skills and knowledge

SAFER CARE

Outcome 9
Community-based suicide crisis care is readily accessible

Outcome 10
Urgent & Emergency access to crisis care

Outcome 11
Offender MH Pathway in place for when released into community

Outcome 12
Preventing and responding to self-harm, ensuring care meets NICE Guidance

Outcome 13
Adoption and full implementation of an Integrated Depression care pathway that meets NICE Guidance

Outcome 14
Implementation of Safer Care: 10 key elements to improve safety in Mental Health and 4 key elements for Primary Care Services

SUPPORT AFTER SUICIDE

Outcome 15
Those bereaved by suicide are able to access suicide bereavement services and resources

Outcome 16
A community response plan can be activated for potential suicide clusters/contagion

Outcome 17
The media delivers sensitive approaches to suicide and suicidal behaviour

INTELLIGENCE

Outcome 18
To establish a data collection and evaluation system to track progress of strategy

Outcome 19
To have a better understanding of the needs of different populations at risk of suicide

Outcome 20
Reduction in access to means and respond effectively to suicide in public places utilising robust and current intelligence
Shifting the outcome

- Foundations in place for achieving outcomes
- Partnerships engaged
- How do we accelerate the pace of change?
- No single solution, no simple solution
- Experts by experience have the opportunity to collaborate for change
‘Take a minute, change a life’

- How can individuals, agencies and partners here today help to shift the outcome?
- Interactive session - your chance to contribute to the outcome
- Pledge for Action - NO MORE Suicide
- #WSPD17
Self-harm and suicidal behaviour

Professor Rory O’Connor, Professor of Health Psychology, University of Glasgow
Self-harm and suicidal behaviour

Rory O’Connor PhD CPsychol AFBPsS FAcSS
Past President, International Academy of Suicide Research
2nd Vice President, International Association for Suicide Prevention
Suicidal Behaviour Research Laboratory
Institute of Health & Wellbeing
University of Glasgow

www.suicideresearch.info
Twitter: @suicideresearch
• Psychological markers of suicide risk

• Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV; O’Connor, 2011)

• From suicidal thoughts to suicidal attempts
  – Fearlessness about death, exposure to suicide, impulsivity
  – Stress response

• Brief intervention to reduce repeat self-harm
  – Volitional helpsheet (VHS)

• Conclusions
Figure 1: Representation of the relative prevalence self-harm and suicide in young people

Keith Hawton, Kate E A Saunders, Rory C O’Connor

Lancet 2012; 379: 2373-82
1. **Surveillance**

What is the problem?

Define the problem of suicidal behaviour through systematic data collection.

2. **Identify risk & protective factors**

What are the causes & what can buffer their impact?

Conduct research to find out why suicidal behaviour occurs and who it affects.

3. **Develop & evaluate interventions**

What works & for whom?

Design, implement and evaluate interventions to see what works.

4. **Implementation**

Scaling up effective policies & programmes

Scale up effective and promising interventions and evaluate their impact and effectiveness.
Why do people kill themselves?
Key risk factors for self-harm and suicide

Keith Hawton, Kate E A Saunders, Rory C O’Connor

Lancet 2012; 379: 2373–82
Although traditional evidence suggests c90% of people who die by suicide have a psychiatric disorder, less than 5% of those with depression die by suicide.

More specific (psychological) markers of suicide risk

Translating suicidal thoughts (ideation) into suicidal acts (attempts)
Integrated Motivational–Volitional Model (IMV)
O’Connor (2011). In O’Connor, Platt & Gordon (Eds.). *International Handbook of Suicide Prevention: Research, Policy & Practice* Wiley-Blackwell
Predicting Suicide Attempts/Suicide over 4 Years

All factors significant univariate predictors

Past S Attempt  
Suicide Ideation  
Depression  
Hopelessness  
Defeat  
Entrapment

No Repeat Attempt  
Repeat Attempt

O'Connor, Smyth, Ryan, Williams (2013)  
Journal of Consulting & Clinical Psychology
Box 1 Conclusions and key future directions

Although there is considerable evidence that entrapment is associated with suicidal ideation and behavior:

- The evidence is stronger for ideation than behavior.
- There is no direct evidence of the relationship between entrapment and suicide.
- Prospective studies of the entrapment–suicidal behavior relationship should be prioritized.
- The extent to which entrapment is affected or activated by negative mood and life stress needs to be explored.
- New technologies (e.g. apps) and statistical techniques (e.g. network analysis) should be harnessed to explore the daily fluctuations in entrapment and the extent to which it affects other risk factors.
- The factors hypothesized to moderate and mediate the defeat–entrapment–suicidality relationships, as specified in the IMV model, require further research attention.
- Novel research designs that take account of the reflective (e.g. social problem-solving) and automatic processes (e.g. implicit attitudes) likely to be involved in the etiology of entrapment are required.
- It is unclear whether entrapment is a culturally sensitive construct or whether it is more pernicious in men versus women and at different stages in life.
- Psychological treatments targeting entrapment should be developed and evaluated.
From suicidal ideation to suicide attempts

- Acting on suicidal thoughts?
  - Theoretical models can help inform understanding of transition
- Those who think about suicide versus those who attempt suicide
  - Fearlessness about death, impulsivity, exposure to suicide
- Stress and wellbeing study
Distinguishing suicidal ideation from suicide attempts

Suicide Ideators (N=583)
Suicide Attempters (N=230)
Controls (N=475)

According to IMV model, volitional phase factors most important in differentiating IDEATION from ATTEMPTS

Motivational Phase Factors (ideation)
- Defeat
- Entrapment
- Goal Regulation
- Burdensomeness
- Belongingness

Volitional Phase Factors (attempts)
- Impulsivity
- Exposure to suicidal behaviour of friend
- Exposure to suicidal behaviour of family
- Fearlessness about death
- Discomfort tolerance

Dhingra, Boduszek, & O’Connor
Journal of Affective Disorders (2016)
### What did we find?

#### Motivational Phase Factors (ideation)
- Defeat
- Entrapment
- Goal Regulation
- Burdensomeness
- Belongingness

#### Volitional Phase Factors (attempts)
- Impulsivity
- Exposure to suicidal behaviour of friend
- Exposure to suicidal behaviour of family
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<tr>
<th>Factor</th>
<th>Difference</th>
</tr>
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<tbody>
<tr>
<td>Defeat</td>
<td>No difference</td>
</tr>
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<td>Entrapment</td>
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<td>Goal Regulation</td>
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Cortisol and the Stress Response
Cortisol & suicidal behaviour

• **Cortisol is the primary effector hormone** of the HPA axis stress response system

• **HPA axis** regulated by a negative feedback system (i.e., hypothalamus & pituitary gland have receptors that detect changes in cortisol levels)

• **Excessive, repetitive activation** may lead to tissue damage & future ill health (cf., allostatic load, McEwen, 1998)

• **Cortisol linked to impairments** in cognitive control, decision-making & emotional processing
Cortisol levels and suicidal behavior: A meta-analysis

Daryl B. O'Connor a, *, Eamonn Ferguson b, Jessica A. Green a, Ronan E. O'Carroll c, Rory C. O'Connor a, *

a School of Psychology, University of Leeds, Leeds, UK
b School of Psychology, University of Nottingham, Nottingham, UK
c Department of Psychology, University of Stirling, Stirling, UK
d Suicidal Behaviour Research Laboratory, Institute of Health & Wellbeing, University of Glasgow, Glasgow, UK

A B S T R A C T

Suicide is a major cause of death worldwide, responsible for 1.5% of all mortality. The causes of suicidal behavior are not fully understood. Dysregulated hypothalamic–pituitary–adrenal (HPA) axis activity, as measured by cortisol levels, is one potential risk factor. This meta-analytic review aimed (i) to estimate the strength and variability of the association between naturally fluctuating cortisol levels and suicidal behavior and (ii) to identify moderators of this relationship. A systematic literature search identified 27 studies (N=2226; 779 suicide attempters and 1447 non-attempters) that met the study eligibility criteria from a total of 417 unique records initially examined. Estimates of effect sizes (r) obtained from these studies were analysed using Comprehensive Meta-Analysis. In these analyses, we compared participants identified as having a past history of suicide attempt(s) to those with no such history. Study quality, mean age of sample and percentage of male participants were examined as potential moderators. Overall, there was no significant effect of suicide group on cortisol. However, significant associations between cortisol and suicide attempts were observed as a function of age. In studies where the mean age of the sample was below 40 years the association was positive (i.e., higher cortisol was associated with suicide attempts; r = .234, p < .001), and where the mean age was 40 or above the association was negative (i.e., lower cortisol was associated with suicide attempts; r = - .129, p < .001). These findings confirm that HPA axis activity, as indicated by age-dependent variations in cortisol levels, is associated with suicidal behavior. The challenge for theory and clinical practice is to explain the complete reversal of the association with age and to identify its clinical implications.

O’Connor, D., Green, J., Ferguson, E., O’Carroll, O’Connor, R. (2017) *Psychoneuroendocrinology*

**Stress & Wellbeing Study: Cortisol reactivity**

- **160 participants**
  - **Controls** 45
  - **Ideators** 53
  - **Attempts** 47
    - **Attempt within 1 year** (n=14)
    - **Historical attempt** (n=33)
      - 8 unclear
      - 6 withdrew
      - 1 high C values

Mean age 26.84 yrs (16-62 yrs) 100 females (62.5%)
Informed Consent → Suicide History Interview and Questionnaire Packet → Rest Period (10 Minutes)

Post-Stress Assessments (Cortisol, Blood Pressure, Heart Rate & STAI-6) → MAST (15 Minutes) → Baseline Assessments (Cortisol, IL-1/IL-6, Blood pressure, Heart Rate, STAI-6)

Recovery Period Assessments at +5, +10, +20, +30 and + 40 minutes → Debrief → 1 & 6 month FU
Physiologically & psychologically challenging

Combines an uncontrollable physical stressor (cold pressor task) with a social-evaluative component (mental arithmetic)

Participants led to believe they are being video recorded and that the duration of the trials is random
Main effect of group for cortisol levels, p=0.02; AUCg, p=0.02, AUCi, p=0.04

Note: All analyses controlled for age, BMI, medication usage, time of day, smoking, & gender
Those who had attempted suicide only and cortisol reactivity (n=47)

- n = 14, < 1 year
- n = 33, > 1 year

Attempt history x time for cortisol levels, p=0.03
Main effect of group for cortisol levels, ns; AUCg, ns, AUCi, p=0.03
Effects of family history of suicide on cortisol reactivity

Family history x Group x Time for cortisol levels, p=0.01
Family history x time, p=0.001 [attempters only]
Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis

Prof Keith Hawton, FMedSci Email, Katrina G Witt, DPhil, Tatiana L Taylor Salisbury, PhD, Ella Arensman, PhD, Prof David Gunnell, FMedSci, Prof Philip Hazell, PhD, Prof Ellen Townsend, PhD, Prof Kees van Heeringen, PhD

THE LANCET Psychiatry

**Interpretation**

CBT seems to be effective in patients after self-harm. Dialectical behaviour therapy did not reduce the proportion of patients repeating self-harm but did reduce the frequency of self-harm. However, aside from CBT, there were few trials of other promising interventions, precluding firm conclusions as to their effectiveness.
From Motivation to Action

Volitional Help Sheet to Reduce Suicidal Behaviour
Help Sheet

We want you to plan to avoid self-harming. Research shows that if people can spot situations in which they will be tempted to self-harm and then link them with a way to overcome those situations, they are much more likely to be successful in avoiding self-harming.

On the left hand side of the page below is a list of common situations in which people feel tempted to self-harm; on the right hand side of the page is a list of possible solutions.

For each situation that applies to you personally (left hand side), please draw a line linking it to a solution (right hand side) that you think might work for you. Please draw a line linking one situation to one solution at a time, but make as many (or as few) situation-solution links as you like. There is a blank situation box and a blank solution box at the bottom for you to include anything else which might also apply to you.

<table>
<thead>
<tr>
<th>SITUATIONS</th>
<th>Please draw lines to the boxes that are relevant</th>
<th>SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I am tempted to self-harm when I want to get relief from a terrible state of mind ...</td>
<td>☐</td>
<td>... then I will do something else instead of self-harming</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I want to punish myself ...</td>
<td>☐</td>
<td>... then I will tell myself that I can stop self-harming if I want to</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I want to die ...</td>
<td>☐</td>
<td>... then I will recall information people have given me about the benefits of stopping self-harming</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I want to show how desperate I am feeling ...</td>
<td>☐</td>
<td>... then I will tell myself that Society is changing in ways that make it easier for people to stop self-harming</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I want to find out whether someone really loves me ...</td>
<td>☐</td>
<td>... then I will make sure I am rewarded by others if I don’t self-harm</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I want to get some attention ...</td>
<td>☐</td>
<td>... then I will think about the impact of my self-harming on the people around me</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I want to frighten someone ...</td>
<td>☐</td>
<td>... then I will remember that I react emotionally to warnings about my self-harming</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I want to get my own back on someone ...</td>
<td>☐</td>
<td>... then I will remember that I get upset when I think about my self-harming</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I feel defeated ...</td>
<td>☐</td>
<td>... then I will put things around my home or place of work that remind me not to self-harm</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I feel trapped ...</td>
<td>☐</td>
<td>... then I will seek out someone who listens when I need to talk about self-harm</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I feel hopeless ...</td>
<td>☐</td>
<td>... then I will take medication</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I ...</td>
<td>☐</td>
<td>... then I will ...</td>
</tr>
<tr>
<td>If I am tempted to self-harm when I ...</td>
<td>☐</td>
<td>... then I will ...</td>
</tr>
</tbody>
</table>
• Full RCT of VHS with a 2 month booster
  ❖ 6 month follow-up (hospital-treated self-harm as outcome)
  ❖ **518** participants
  ❖ 259 received VHS + treatment as usual TAU (intervention group)
  ❖ 259 received TAU (control group)

• Primary outcomes
  ❖ Proportion of people who re-present to hospital with self-harm in next 6 months
  ❖ Number of times people re-present to hospital with self-harm in next 6 months
  ❖ Cost effectiveness of the VHS

• ITT and PP (n=248 who completed VHS) analyses
• Past history of self-harm hospitalisation as moderator
A brief psychological intervention to reduce repetition of self-harm in patients admitted to hospital following a suicide attempt: a randomised controlled trial

Rory C O'Connor, Eamonn Ferguson, Fiona Scott, Roger Smyth, David McDaid, A-La Park, Annette Beauchais, Christopher J Armitage

Summary

Background We investigated whether a volitional helpsheet (VHS), a brief psychological intervention, could reduce repeat self-harm in the 6 months following a suicide attempt.

Methods We did a prospective, single-site, randomised controlled trial. Patients admitted to a hospital in Edinburgh, UK, after a suicide attempt were deemed eligible for the study if they were over the age of 16 years, had a self-reported history of self-harm, were fluent in English, were medically fit to interview, and were not participating in other research studies within the hospital. Eligible patients were randomly assigned (1:1), via web-based randomisation to receive either VHS plus usual treatment (intervention group) or only treatment as usual (control group). Randomisation was stratified by sex and self-reported past self-harm history. The Information Services Division of the National Health Service (NHS-ISD) staff and those extracting data from medical notes were masked to which study group the participant was allocated to. Clinical staff working within the hospital were also masked to participants’ randomisation status. There were three primary outcomes: the proportion of participants who represented to hospital with self-harm over the 6-month follow-up period; the number of times a participant represented at hospital with self-harm during the 6-month follow-up period; and cost-effectiveness of the VHS as measured by estimated incremental cost per self-harm event averted. Primary outcomes were analysed in all randomised patients. Follow-up data collection was extracted from the Information Services Division of the NHS and from patient medical records. Primary outcomes were analysed in the intention-to-treat population. The trial is registered with International Standard Randomised Controlled Trial Number Registry, number ISRCTN99488269.
What did we find? Number of people who self-harmed (ITT)

No effect on the number of people admitted to hospital with self-harm in following 6 months
Percentage of participants who self-harmed (overall) as a function of past history of hospital-treated self-harm (PP analyses)

History: 8.6%, 95%CI -1.34 – 18.54, p=.087; NNT = 1 in 12
No History: -8.3%, 95%CI -3.51-20.11, p=.17; NNH = 1 in 13

Needs replication as post-hoc analyses
Repeat hospital-treated self-harm as function of self-harm history and treatment allocation (number of admissions; ITT)

Control group: those with past history, higher levels of repeat self-harm

For those with self-harm history, trend that intervention associated with reduced self-harm

$p = .001$

$p = .10$

Mean A&E Admissions

Self Harm in the last 10 years
Repeat A&E hospital treated self-harm as function of self-harm history and treatment allocation (Per Protocol Analysis)

Self-harm history associated with increased repeat self-harm incidence

Those in intervention arm with self-harm history have significantly lower repeat self-harm incidence

O’Connor et al. (2017). Lancet Psychiatry
Repeat hospital treated (total) self-harm as function of self-harm history and treatment allocation (Per Protocol Analysis)

Same pattern of findings as for A&E presentations

Those in intervention arm with self-harm history have significantly lower repeat self-harm incidence

Self Harm in the last 10 years
O’Connor et al. (2017). Lancet Psychiatry
Conclusions

- Suicide is a psychological phenomenon affected by social, biological, clinical and cultural factors

- Theoretical models important to guide research
  - Differentiate between ideators vs enactors
  - Understanding how, why, when factors increase/decrease risk

- Theoretical models can inform intervention development

- Important to develop interventions which target:
  - Emergence of suicidal ideation (motivational phase)
  - The intention–behaviour gap (volitional phase)
Suicide by Children and Young People

Professor Louis Appleby

Director, National Confidential Inquiry
Chair, National Suicide Prevention Strategy (England)

Working together to improve health and wellbeing in Cheshire and Merseyside
Professor Louis Appleby

Director, National Confidential Inquiry
Chair, National Suicide Prevention Strategy (England)
World Suicide Prevention Day 2017

- 800,000 suicides per year worldwide
- 16 million self-harm episodes per year
- Second leading cause of death in 15-29 year olds

Source: ONS
Suicide rates in STP ‘footprint’ areas

- Variation by geography
- Highest rates in north & south-west
- Lowest rates in London
Local priorities

- Men
- Self-harm
- Acute mental health care
- Depression in primary care
- Children and young people
- High frequency locations
- Isolation
- Bereavement support
Age-specific suicide rate, 2015, England

Source: ONS
Self-harm rates in Manchester

Source: MASH project
Percentage of population who report self-harm

Source: NatCen 2016
Suicide rates in 15-19 year olds, 2000-2015

- All persons
- Males
- Females
Suicide in C&YP: national study

January 2014 – December 2015

922 suicides (England & Wales)

- 316 under 20
  - all inc. in sample
- 606 aged 20-24
  - 124 (20%) inc. in sample

391 (89%) reports available
Suicide in C&YP

- Number of suicides at each age rises steadily in late teens/early 20s
- Mainly males (76%)
- Hanging the most common method
- Peak in number of suicides in April/May
Suicide in C&YP: method

Use of self-harm methods likely to be fatal
Suicide in C&YP: timing
Suicide in C&YP: main themes

- Students
  - Exam stresses common
- ‘Looked after’ children
  - Housing and mental health problems common
- LGBT young people
  - Bullying and self-harm common
- “Out of the blue”
  - Around 1/3 had few warning signs

Ten common themes in suicide by children and young people:

- Family factors such as mental illness
- Abuse and neglect
- Bereavement and experience of suicide
- Bullying
- Suicide-related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have social impact
- Alcohol and illicit drugs
- Mental ill health, self-harm and suicidal ideas
Suicide in C&YP: stresses

- **Academic pressures**: More frequent in under 20s
- **Economic adversity**: Workplace & financial problems more common in 20-24 year olds
- **Bullying**: A fifth of under 20s had been bullied, face to face or online
- **Housing problems**: 20-24 year olds reported more problems with accommodation

- Sources of stress reflect age-related changes in lives of young people
Suicide in C&YP: internet use

- Searching for suicide methods
- Posting suicidal messages
- On-line bullying
Suicide in C&YP: recent service contact

- Most in contact with children’s services at some time

- Under half in current contact
Suicide in C&YP: self-harm

- Psychosocial assessment linked to better outcome
- Evidence supports follow-up with CBT / DBT

Self-harm: key to suicide prevention, especially working with substance misuse services

52% under 20s
41% 20-24 year olds

High rates of alcohol & drug misuse, especially in 20-24 year olds
Model of suicide risk in C&YP

Cumulative risk:
1. Traumatic experiences in early life
2. Adversity & risk behaviours in adolescence
3. Recent stressful event

Prevention measures:
1. Support for young children and their families
2. Access to CAMHS including self-harm & substance misuse services
3. Crisis support, healthy workplaces and campuses
Suicide prevention in children and young people

- role for CAMHS, primary care, education, social care, families
- bereavement support
- internet safety
- self-harm care
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Website:
http://www.manchester.ac.uk/nci
- Follow link to National Confidential Inquiry

Like us on Facebook
https://www.facebook.com/pages/Centre-for-Mental-Health-and-Safety

Follow us on Twitter
https://twitter.com/NCISH_UK
Refreshment break

Please be back at 3:00pm

CALM
0800 58 58 58

Samaritans
116 123

SOBS
0300 111 5065

AMPARO
0330 088 9255

Papyrus
0800 068 41 41

www.hubofhope.co.uk

Champs
Public Health Collaborative

Working together to improve health and wellbeing in Cheshire and Merseyside
Hub of Hope

Angela Samata

Working together to improve health and wellbeing in Cheshire and Merseyside
There's always somebody to talk to

Filter services

Locating you...  ○

Or find by postcode

Postcode Find

Talk Now

Imagine Independence
25 Hope Street

2.64 miles away

Call them

Open today (09:00 – 16:30)

Talk Now

Mashbo

Chasing Stigma
Prevention of young suicide

Alice Newton, National Training Development Manager, Papyrus

Working together to improve health and wellbeing in Cheshire and Merseyside
We work towards: **building a society which speaks openly about suicide and has the resources to help young people who may have suicidal thoughts**
Our History

- Began in 1997 by a group of parents who lost their child to suicide
- Parents, family and friends have a unique perspective
- Many young suicides can be prevented
- The charity was founded
Our present

- National charity
  - Warrington (HQ)
  - Birmingham
  - London
- Helpline service
- Training provider
- Campaigner
- Community Projects
HOPELineUK 0800 068 41 41

• Professional Suicide Prevention Advisors
  – Practical advice
  – Links to local/specialist services across UK

• Intervention Policy

• Text and email advice
  – email pat@papyrus-uk.org
  – SMS 07786 209697

• Mon- Fri 10-10pm, Weekends & Bank hols 2-5pm
HOPELineUK contacts

<table>
<thead>
<tr>
<th>Year</th>
<th>Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
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<tr>
<td>2014</td>
<td></td>
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<tr>
<td>2015</td>
<td></td>
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<tr>
<td>2016</td>
<td></td>
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<tr>
<td>2017 (est)</td>
<td>80,000</td>
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</tbody>
</table>

HOPELineUK 0800 068 41 41
“Over the last few weeks you have all been amazing, I can’t thank you enough, honestly you’ve kept me going”
*Text service*

“Thank you you've been more help than anyone else I've spoken to”
*Phone Call*

“I can positively say that you have made me calmer. You’ve been amazing, it sounds like you’ve been here for a long time and it has been a fantastic call”
*Phone call*

“I saw my GP after a suicide attempt, thanks for steering me that way”
*Text service*
Applied Suicide Intervention Skills training (ASIST)

Following training, participants will be able to provide a suicide intervention model which includes:

- Identifying people who have thoughts of suicide
- Reach out and offer support
- Seek a shared understanding of the reasons for thoughts of suicide and the reasons for living
- Work collaboratively with the person at risk of suicide to develop a plan to increase safety from suicidal behaviour
- Link people with community resources

(2 day course), recommended by the DoH and first suicide prevention course to be listed under the National Registry of Evidence-based Programs and Practices (NREPP)
PAPYRUS is looking for adults to help #SaveYoungLives and #TalkThroughTheTaboo of young suicide by:

• Being one of 60 community members trained in ASIST (Applied Suicide Intervention Skills Training)

• Delivering at least one suicide prevention activity within their chosen community

• Warrington 7th - 8th and 14th - 15th October here at the Halliwell Jones

www.papyrus-uk.org/about/volunteer-for-papyrus
If Only …

• friends / family do not always see invitations
• we need to let others know that young suicide is a major concern in our country
• we need to let each other know that there is HOPE and it is possible and OK to seek help
• PAPYRUS can offer and get you help
• You can help to #savemyounglives

HOPELineUK  0800 068 41 41
You can help to #saveyounglives

/PAPYRUSuk  @PAPYRUS_tweets

HOPELineUK  0800 068 41 41

prevention of young suicide
THANK YOU

#saveyounglives
Pledges for action
Interactive session hosted by Merseyside Youth Association
Summary of event, next steps and closing remarks
Thank you for attending
Please complete your evaluation form and pledge form
The presentations can be accessed following the event via www.champspublichealth.com