A desk based review of probable suicides amongst children and young adults in Mid and West Wales – Concise Report

Dr. Tom Slater

Correspondence

Please direct any correspondence regarding the methodology or findings to the author of this report, Dr. Tom Slater (slatertb1@cardiff.ac.uk). Any queries for the Mid and West Wales Safeguarding Board should be directed to Julie Breckon (Julie.Breckon@pembrokeshire.gov.uk).

If you wish to make a complaint regarding any ethical issues in this study, then please contact the Chair, Professor Emma Renold (renold@cardiff.ac.uk), of Cardiff University's School of Social Sciences Research Ethics Committee (SREC).

Requests for Freedom of Information (FoI) can be made via the author or by contacting Cardiff University's Information Rights Team (inforequest@cardiff.ac.uk)[1].

Press and media enquiries should ensure that they are aware of the Samaritan Media Guidelines For Reporting Suicide (2013) (https://www.samaritans.org/your-community/samaritans-work-wales/media-guidelines-wales).

Copyright

Referencing this document

This document should be referenced as follows:

Slater, T (2017) *A desk based review of probable suicides amongst children and young adults for Mid and West Wales Safeguarding Board*. Cardiff: Cardiff University

[1] More information is available on the Cardiff University website - https://www.cardiff.ac.uk/public-information/freedom-of-information. Please note: Any FoI requests related to information held by the Mid and West Wales Safeguarding Board will be managed in accordance with stipulated set out under the Freedom of Information Act 2000. Equally, any FoI request raised with the Safeguarding Board for data held by Cardiff University will be similarly managed.

Acknowledgement and thanks

I would like to acknowledge the young people who have died from probable suicided, their bereaved families and friends as well as those professionals who have sought to support both these young people and their loved ones. Through research and enhanced practice, we might strive to reduce future deaths.

Thanks to Julie Breckon, Maxine Thomas and Wendy Butcher for their assistance in providing materials for this report.

Table of contents

Concise report

Introduction: Every suicide affects a family and a community. This is particularly true when the death is that of a child or young adult. They are tragic events that we should strive to learn from with a view to preventing future occurrences. Thankfully suicides are rare events, however, they remain the leading cause of death for young people in Wales. This review provides some insight into what can be learnt from child and young adult (aged 20 or under) - the term young person is used to encompass both - suicides in Mid and West Wales.

Aims and objectives: This review had two objectives: (i) to explore wider evidence that might be utilised in local prevention strategies and practice, and (ii) to thematically review Serious Case Reviews (SCRs), Child Practice Reviews (CPRs), Procedural Response to Unexpected Deaths in Children (PRUDiC) minutes, Adult Practice Reviews (APRs), multi-agency review meetings/forums and other relevant documents to determine what opportunities for future preventative work. These objectives haven been met through two work streams:

1. Desk-based review of existing literature
2. Thematic analysis of reviews into death by probable suicide

Method: The desk-based review of existing literature comprised of a search of searches of academic databases for research into suicide amongst children and young adults. Articles were appraised or both relevance and quality. For the thematic review of deaths by probable suicide, cases were identified by colleagues within the Mid and West Wales Safeguarding Board and its partner agencies. These documents were qualitatively analysed using thematic analysis. A total of 16 suicides in young people over a ten-year period were reviewed.

Findings from the literature review: Suicide is a leading area of preventable deaths accounting for 800,000 deaths globally each year (WHO 2017); the equivalent of one every 40 seconds. In Great Britain, there were 5,668 recorded suicides during 2016, 322 suicides were in Wales (ONS 2016b; 2017c). This is approximately three times the number of deaths from road accidents (Department for Transport 2016). Worryingly, suicide is the leading cause of death for young people (ONS 2016a). It is perhaps unsurprising then that suicide has been the subject of

considerable discussion by sociologists, psychologists, psychiatrists, epidemiologists, medics and many other disciplines.

The field of suicidology (the study of suicide) is expansive and the diversity of research serves as testament to the multifaceted nature of suicide. Interlinked biological, sociological and psychological factors all play a part in suicidality making it difficult to predict. The complexity of risk and protective factors is illustrated in Figure 1:

Figure 1 – Psychological risk and protective factors for suicide

Personality and individual differences Hopelessness; impulsivity perfectionism; neuroticism and extroversion; optimism; resilience.	*Cognitive factors* Cognitive rigidity; rumination; thought suppression; autobiographical memory biases; belongingness and burdensomeness; fearlessness about injury and death; pain sensitivity; problem solving and coping; agitation; implicit associations; attention biases; future thinking; goal adjustment; reasons for living; defeat and entrapment.
Social factors Social transmission; modelling; contagion; assortative homophily; exposure to death by suicides of others; social isolation	*Negative life events* Childhood adversity; traumatic life events during adulthood; psychical illness; other interpersonal stressors; psychophysiological stress response.

Note, this adapted from the British Psychological Society (2017) which is in turn an adaptation of O'Connor and Nock (2014).

The manifestation of these factors is unique in each individual, but we are able to gain some knowledge about wider trends in suicide that indicate the elevated risk for certain groups. These have been summarised in the following pages.

Young males are significantly more likely to take their lives than females. 76% of child and young adult suicides reviewed by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCIHS) (2017) were male. Specific triggers for males seem to be: relationship

breakdown; a history of criminal/deviant behaviour; and exhibiting high levels of aggression and impulsivity.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCIHS) reviewed suicide in children and young people for the years 2014 and 2015, this review identified ten key themes (2017:4):

1) *Family factors such as mental illness*
2) *Abuse and neglect*
3) *Bereavement and experience of suicide*
4) *Bullying*
5) *Suicide-related internet use*
6) *Social isolation and withdrawal*
7) *Academic pressures, especially related to exams*
8) *Physical health conditions that may have social impact*
9) *Alcohol and illicit drugs*
10) *Mental ill-health, self-harm and suicidal ideas*

In addition to these factors the following should also be considered risk factors: young people who are, or have been looked after children; LGBTQ++ young people and those with impaired cognition/learning disabilities.

Beyond risk and protective factors the literature review also examined the evidence base for preventing, assessing and intervening in suicide. Approaches to preventing suicide amongst young people, necessitates a diverse set of interventions operating at multiple levels.

Suicide scales, measures and tools are ineffective in predicting future suicides. Contemporary NICE (2011) guidance advises that assessments should take place after instances of attempted suicide and self-harming behaviour, however, scales/measures/tools should not be utilised. Instead practitioners should adopt a person-centred approach that considers the unique circumstances of the individual and draws on the wider evidence base. Training practitioners about suicide is therefore particularly important.

Psychological interventions such as Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), problem solving and group-therapy are useful for preventing self-harm and suicide amongst adults but there is little high-quality evidence to validate its effectiveness amongst children and young people.

Public awareness and education based awareness programmes have a limited and mixed evidence base. Educating professionals in community based roles to watch for risk factors is beneficial.

Pharmacological interventions can be effective, however, the use of Selective Serotonin Reuptake Inhibitors (SSRIs) in young people is divisive. Further to this, pharmacological interventions are an important part of suicide prevention but they are at their most effective when provided in conjunction with wider services and support.

Inappropriate and poorly considered reporting of suicide within the media can result in increases in suicidality (this is known as the Werther effect). Media guidelines for reporting suicide should be scrutinised by statutory services and used to inform discussions with the media. Media outlets should carefully consider guidelines to promote responsible reporting.

For young people, careful consideration needs to be given when intervening in instances of acute suicidality. A range of options will often exist and services need to establish which is the most appropriate. Further to this, the transition from children to adult services can be a time of heightened anxiety for young people and their families. The different configuration and threshold of children and adult focused services gives rise to complexity, and poorly managed transitions can serve to heighten anxiety and uncertainty, and in turn issues of suicidality. Many young people often leave services at the transition from children to adult services meaning that they have limited support. Integrating third sector services would likely aid with those struggling to access, or exiting from, statutory services.

Finally, a patchwork of legal and policy frameworks need to be drawn on when preventing and intervening in instances of suicide. Practitioners need to have a working knowledge of primary and secondary legislation in a range of areas: mental health; mental capacity; substance misuse; safeguarding (both adults and children); learning and physical disabilities; as well as wider care and support frameworks. Similarly, strategic planning in these areas is also important for preventing suicides.

Empirical findings: The empirical findings are described under four broad themes -

Access to means

All bar one of the young people either hung, or otherwise asphyxiated, themselves. Preventing suicide by hanging/asphyxiation is difficult due to the ready availability of means. Dispelling the belief held by some that it is a painless and quick death raises the risk of unintentionally providing

clarity on how the method, or other methods, can most effectively be employed. Practitioners should avoid this and should instead focus on: (i) identify those at risk prior to the act and (ii) universal forms of support and intervention.

Risk factors

- Bereavements - Recent bereavements, particularly where the death is the result of suicide, serve to heighten the risk of suicide amongst young people. Bereavement support should be provided to help guard against this.
- Adverse Childhood Experiences (ACEs) - Instances of neglect, emotional, physical and sexual abuse were noted in at least half of the young people.
- Children who are looked after – Four of the young people completed the act of suicide whilst in the care of the local authority. Multiple moves and poor transition planning to adult services were noted to heighten risk. Training foster carers about suicide would likely be beneficial.
- Special Educational Needs (SEN) and Additional Learning Needs (ALN) – Viewed in isolation these do not seem to be a risk factor, however, they can serve to exacerbate wider issues and reduce the individual resilience of young people.
- Chaotic family backgrounds - Chaotic family backgrounds with multiple moves were common to many young people. Poor parental mental health and deviant/criminal parental activity were also noted to be risk factors.
- Mental disorders, self-harm, substance misuse and criminal/deviant behaviours - The presence of mental disorder, substance misuse, deviant or criminal behaviours and heightened aggression all increase the risk of suicide. Aggression in males was noted to be a particular risk factor. Where these issues intersect the risk appears too significantly increase.
- Peer groups and social media – Peers were sometime notified of a young person's intention to end their life. Educating young people to identify and respond to warning signs is recommended. Social media often acted as a conduit for communication between young people. Some instances of bullying were noted in a small number of cases.

The role of professionals and service

- Practitioner knowledge – Suicide can appear in all areas of practice and there were examples of good practice. From the data available, it was not possible to ascertain the level of training staff receive on suicide prevention. Staff from all agencies, and at all levels, should be trained in suicide prevention. Training opportunities should be offered to foster carers and colleagues in the third sector.

- Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) – Five observations were made in relation to CAMHS and AMHS: (i) eligibility criteria for mental health services did not always seem to be clear and readily available; (ii) similarly, details about the process for assessment did not seem to have been provided, or otherwise explained, to young people, their families and other agencies; (iii) more effective communication and multi-agency working is could be achieved between CAMHS, AMHS and other services (both in statutory and non-statutory services) to ensure therapeutic alignment in the support young people receive (other services need to work in a manner that compliments the work of CAMHS/AMHS); (iv) transitions between child and adult mental health can be a source of anxiety and uncertainty in young people; and (v) work undertaken by CAMHS and AMHS need to be person-centred and clearly communicated to other agencies.
- Education – Education services are often integral to supporting young people. Young people should be educated about suicide so that they are able to identify and report warning signs.
- Third sector partners - In supporting young people, we need to recognise who is important to them, rather than services trying to insert a professional into their lives. Training should be offered to non-statutory agencies to aid them to identify, report and respond to suicidality.
- PRUDiC – This process was noted to be effective in reviewing and responding to the deaths of young people. Consideration should be given to using this process in the case of probable suicides amongst young adults.
- Responses to deaths – These were handled in a sensitive and considered manner. Support for bereaved families and other young people was provided and agencies seem to have been well coordinated. The *Help is at hand (Cymru)* (NHS Wales, 2013) leaflet should be provided to bereaved families along with details of local services. It was unclear how professionals were supported in the aftermath of a young person's death, clear support mechanisms are needed.

Young males

Young males are particularly vulnerable to suicide, reasons for this include:

- Relationship breakdown – Young males who have experienced a relationship breakdown were noted to be particularly vulnerable to suicide. Where these are observed services should encourage young people to seek support and provide them with space to talk through their emotions.
- Aggressive and impulsive behaviours – Aggressive behaviours have been linked to impulsivity. These heighten the risk of a young person taking their own lives. Improving emotional literacy

through education, developing coping strategies and the provision of safe spaces to talk would likely aid with reducing the risk posed.

Recommendations

1) **Training and support** – Supporting people with suicidal ideation and behaviours should not be seen as the exclusive preserve of statutory mental health services.

   - Training on suicide, such as the ASIST programme, safeTALK and Mental Health First Aid should be made available to staff (both professional and support staff) in both statutory and non-statutory agencies. Ideally, any training should be styled in a train-the-trainer model to ensure sustainability. By training practitioners in all areas, they will be able to more effectively identify and assess suicidality.

   - Services and support offered by third sector agencies should be identified and working relationships with statutory services clearly set out. The newly formed (or forming) Information Advice and Assistance (IAA) services should have up-to-date records of services that can provide support with suicidality, mental well-being, mental health, substance misuse, bereavement support, relationship breakdown and financial support.

   - Where CAMHS and AMHS are supporting an individual, other services should ensure that there are working in therapeutic alignment with the support being provided.

2) **Accessing help and support** - Mental health services find themselves in a period of unprecedented demand. Further to this, the multifaceted nature of suicide means that there are a multitude of different factors that can impact on a person's suicidality. To aid wider services to work with people experiencing suicidal ideation/exhibiting suicidal behaviours, mental health services need to be operating in a transparent and clear manner with other services, this includes identifying wider sources of support when they are not able to support a child/young person. Practical recommendations on this point are identified below:

   - Clear and readily available eligibility criteria for both children and adults' mental health services needs to be provided. This should include details about the assessment process for mental health services. Simple leaflets on this might serve to reduce anxiety and frustration.

   - Where mental health services eligibility is not met, or where a person is being discharged, wider services should be signposted. This should include services available in the third

sector. Similarly, any rights under the Mental Health (Wales) Measure 2010, or other appropriate legislation, should be clearly identified.

- Where mental health services provide support to a young person, clarity in the work being undertaken is needed. Reviews under the Mental Health (Wales) Measure 2010 and the Mental Health Act 1983 (as amended by the Mental Health Act 2007) should serve as points for reflection.

- Work being undertaken by mental health services should be effectively communicated with other agencies. This might mean identifying barriers to communication and/or devising new ways of sharing information.

- Transitions between services should be carefully managed to avoid heightening anxiety amongst young people. Planning of transitions is a joint responsibility and should start as early as possible. Barriers need to be identified. This is true of both mental health services and wider transitions between children and adult services (including Looked After and Accommodated Children)

3) **Monitoring and review** – Four practical measures might be taken here:

- Recording probable suicide – The cause of death is not systematically recorded and collated across the region. This makes identifying probable suicides difficult. Ideally, electronic systems should be amended to capture this information to aid with future learning. This might be undertaken through regional implementation of the National Minimum Core Data Sets under the Social Services and Well-being (Wales) Act 2014, or through changes to social care databases.

- Responses to adult deaths – For children, the PRUDiC process seems to be effective in responding to probable suicide. This might be replicated for adults where it is felt their death might be a probable suicide (some criteria would need to be devised for this).

- A protocol for supporting staff with bereavement should be devised. This will ensure consistency of support and reduce both emotional distress and anxiety. This could be included in the PRUDiC process and any similar model devised for adults.

- Bereaved families should be provided with the *Help is at hand* (NHS Wales, 2013) leaflet as well as details about local support services.

Practical advice

1) There is no evidence that talking to an individual about suicide increases the risk of suicide; there is some evidence that it can in fact be beneficial.

2) An attempted suicide(s) serves to heighten risk **not** reduce it.

3) Not all those who self-harm are suicidal, however, those who do are at an elevated risk of suicide.

4) Sudden changes of mood, particularly where there is a positive improvement, can indicate that a person has made the decision to attempt to end their lives. A healthy scepticism in rapid mood changes is strongly encouraged.

5) Some other behaviours to look out for (adapted from NSPCC 2014 review of Serious Case Reviews):
   - Changing sleeping patterns including sleeping more or less
   - Self-neglect including a decline in personal hygiene and appearance
   - Withdrawing from friends and family and disengaging with services
   - Bereavements, particularly when the death is from suicide, can be particularly dangerous
   - Feelings of hopelessness, rejection and being burdensome
   - Mood swings
   - A history of impulsive and/or aggressive behaviour

6) Adopt a person-centred approach - Motivations for suicide are unique to each person, listen to the individual circumstances of the people you work with to watch for unique warning signs. Do not use scales, measures or tools as a way of predicting future suicidality.

7) Sharing information is important to understand each individual and for understanding the risk of suicide. Remember that young people may choose to engage with people outside of statutory services.

8) Supporting the bereaved – Multi-agency responses to completed suicide should consider who is best placed to support peers, family members, communities and the professionals.

Recommended further reading

- British Psychological Society. 2017. *Position Statement: Understanding and Preventing Suicide: a Psychological Perspective.* Available at: https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Understanding%20and%20preventing%20suicide%20-%20a%20psychological%20perspective.pdf (Accessed 25.09.17)

- Hawton, K., Saunders, K.E. and O'Connor, R.C., 2012. Self-harm and suicide in adolescents. *The Lancet*, *379*(9834), pp.2373-2382.

- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. 2017. *Suicide by Children and Young People*. Available at: http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/cyp_2017_report.pdf (Accessed 19.09.17)

- National Society for the Prevention of Cruelty to Children (NSPCC). 2012. *Suicide: Learning from case reviews*. Available at: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/suicide/ (Accessed 20.09.17)

- O'Connor, R.C. and Nock, M.K., 2014. The psychology of suicidal behaviour. *The Lancet Psychiatry*, *1*(1), pp.73-85.

- Public Health Wales. 2014. *Thematic review of deaths of children and young people through probable suicide, 2006-2012*. Available at: http://www2.nphs.wales.nhs.uk:8080/ChildDeathReviewDocs.nsf/5633c1d141208e8880256f2a004937d1/ce6956a584dd1f6b80257c9f003c3fa1/$FILE/PHW%20probable%20suicide%20web.pdf (Accessed 19.09.17)

- Samaritans. 2013 *Media Guidelines for Reporting Suicide.* Available at: https://www.samaritans.org/your-community/samaritans-work-wales/media-guidelines-wales (Accessed 19.09.17)

References

British Psychological Society. 2017. *Position Statement: Understanding and Preventing Suicide: a Psychological Perspective.* Available at: https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Understanding%20and%20preventing%20suicide%20-%20a%20psychological%20perspective.pdf (Accessed 25.09.17)

Department for Transport. 2016. *Reported Road Casualties in Great Britain: main results 2015*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533293/rrcgb-main-results-2015.pdf (Accessed 15.05.17)

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. 2017. *Suicide by Children and Young People*. Available at: http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/cyp_2017_report.pdf (Accessed 19.09.17)

National Health Service Wales. 2013. *Help is at hand (Cymru)*. Available at: https://uksobs.org/wp-content/uploads/2017/07/HelpIsAtHand-Cymru.pdf (Accessed 19.09.17)

National Institute for Health and Care Excellence. 2011. *Do not use risk assessment tools to predict future suicide or repetition of self-harm* Available at: https://www.nice.org.uk/donotdo/do-not-use-risk-assessment-tools-and-scales-to-predict-future-suicide-or-repetition-of-selfharm (Accessed 19.09.17)

O'Connor, R.C. and Nock, M.K., 2014. The psychology of suicidal behaviour. *The Lancet Psychiatry*, *1*(1), pp.73-85.

Office for National Statistics. 2017a. *Suicides in Great Britain: 2016 registrations*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration (Accessed 19.09.17)

Office for National Statistics. 2017b. *Suicide occurrences England and Wales.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables (Accessed 19.09.17)

Samaritans. 2013. *Media Guidelines for Reporting Suicide*. Available at: https://www.samaritans.org/your-community/samaritans-work-wales/media-guidelines-wales (Accessed 19.09.17)

World Health Organization. 2017. *Suicide Fact Sheet*. Available at: http://www.who.int/mediacentre/factsheets/fs398/en/ (Accessed 22.09.17)