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

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Structure

- Introduction
- What do we know about suicide?
- How do we prevent suicide?
- Training and resources
- Summary
- Questions

Focus

1) Explore suicide generally – we will talk about issues outside of the research and will also touch on issues related to adult suicide

2) The desk-based review – specific discussions will take place of the research (I'll make sure to identify when and were I am doing this)

No magic wand…

I do not have a magic wand, nor am I going to say suicide is easy to prevent. It is a complex and multifaceted issue. Through research we can strive to learn and prevent future deaths but we will make mistakes.

Ground rules for this morning

1) Confidentiality

2) Respect for different positions and ideas

3) There is no such thing as a silly question!

What is this research about?

Aims and objectives of the research

This review had two objectives:

(i) to explore wider evidence that might be utilised in local prevention strategies and practice, and;

(i) 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.

Methods

These objectives were met through two work streams:

- **Desk-based review of existing literature** – This was primarily UK focused and orientated towards children and young adults.

- **Thematic analysis of reviews into death by probable suicide** - A total of 16 suicides in young people over a ten-year period were reviewed. Cases were identified by colleagues within the Mid and West Wales Safeguarding Board and its partner agencies.

Terms and language

- **Committed vs. completed** - Try to avoid using the term ‘committed suicide’ it has connotations of criminality and/or being ‘committed’ to an asylum (i.e. Victorian mental health). The Suicide Act (1961) removed this the common law notion of suicide as a crime. Instead the preferred phrase is ‘completed’.

- **Survivor** – This is a person who has been bereaved by suicide. It is not someone who has survived an attempt to take their life.

What do we know about suicide?

Leading cause of preventable deaths

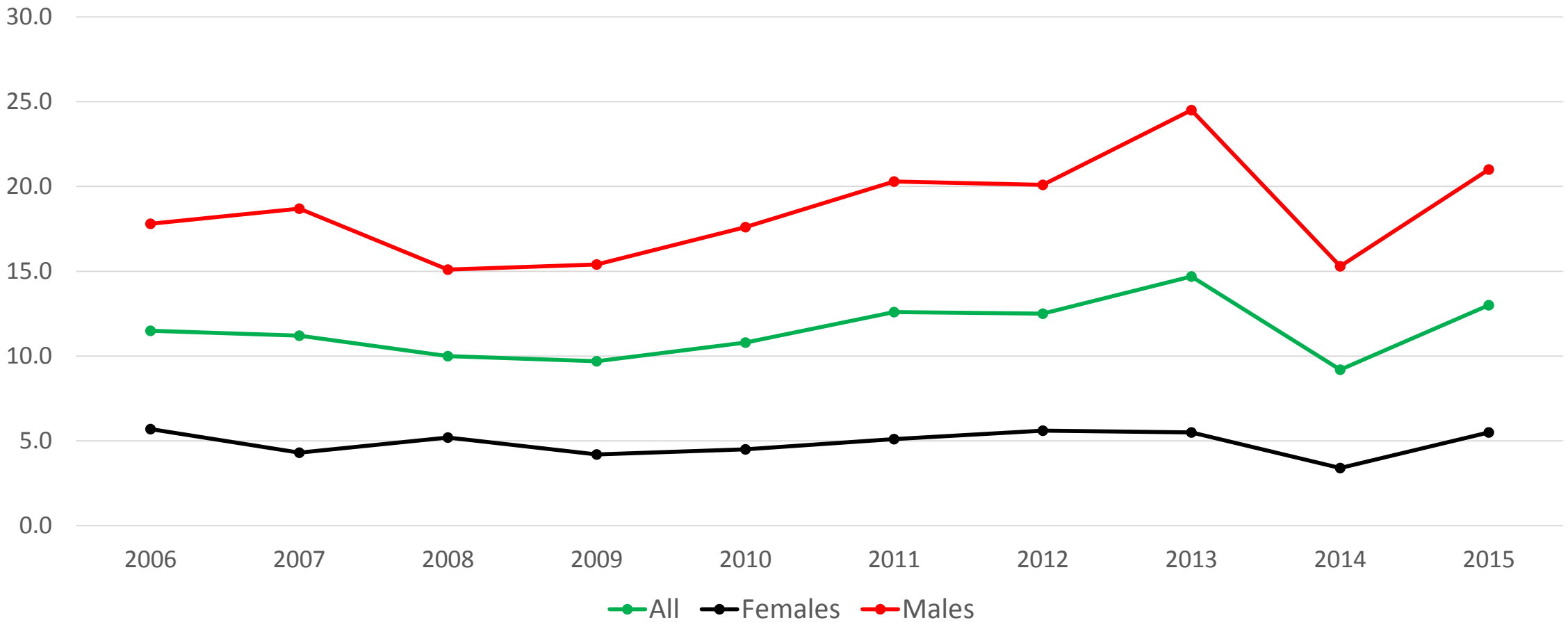
- The World Health Organization (WHO) estimates that there are close to 800,000 suicides globally each year, the equivalent of one person every forty seconds (WHO, 2017)

- The suicide rate amongst males is roughly five times that of females. Females have higher rates of self-harming but lower rates of suicide.

- Suicide is the leading cause of death of young males. However, the highest frequency is amongst middle aged males.

Suicides in Wales

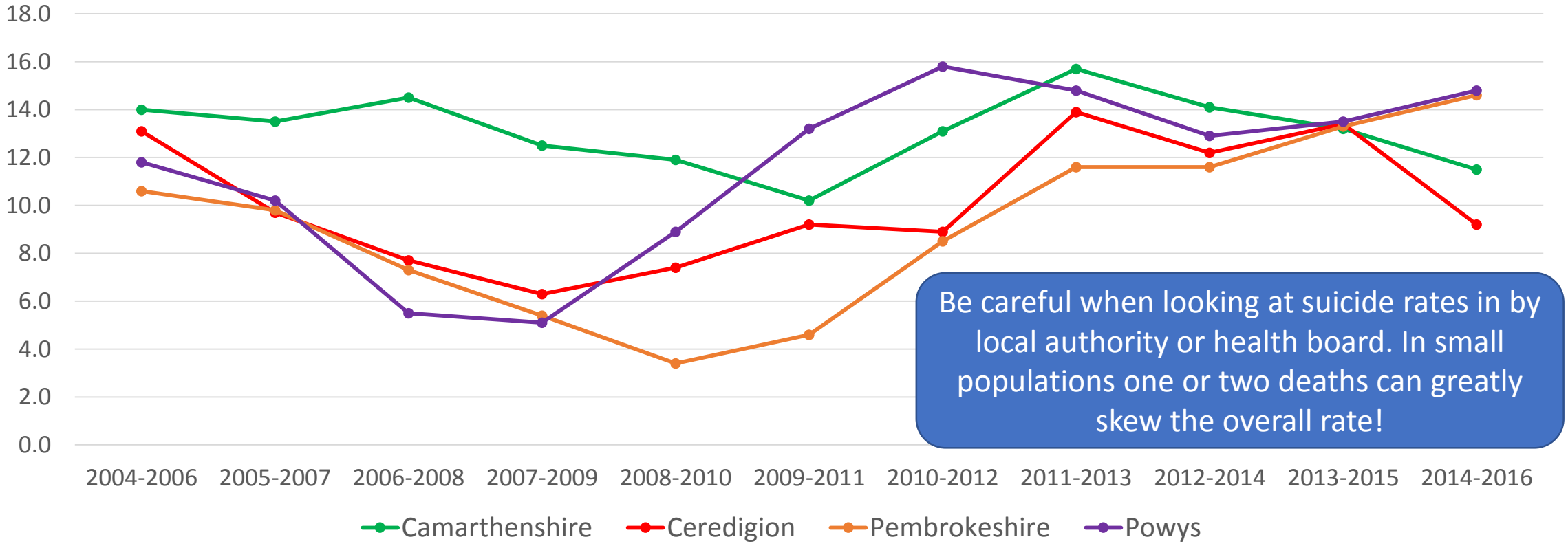
Graph 1 – Age-standardised suicide rates (per 100,000) by sex in Wales between 2005 and 2016



All data in the following tables below utilises the ONS definition of suicide (ICD-10 codes X60-X84 (intentional safe-harm), Y10-Y34 (injury/poisoning of undetermined intent) and Y87.0-Y87.2 (sequelae of intentional self-harm/event of undermined intent).

Suicides in Mid and West Wales

Graph 2 – Age-standardised suicides rates (per 100,000) in rolling three year aggregates in Mid and West Wales between 2004 and 2016



NOTE: (i) For Lower Confidence Limits and Upper Confidence Limits please see ONS (2017c) Table 2. (ii) Due to the weighting process undertaken by the ONS it is not possible to aggregate the rate for Mid and West Wales area. The different populations across the four local authorities means the rate per 100,000 cannot be devised from the publicly available data.

Cluster suicides

There are lots of way to conceptualise ‘cluster’ suicides:

- **Mass clusters** - media related (the Werther effect - more on this later…)
- **Point clusters** – Time or space associations
- **Geographical clusters** – London Underground (the ‘helicopter’ approach)
- **Online(?)** – This might fit under other explanations but it is increasingly being seen as a category in its own right. It can be very difficult to quantify and measure.

Often explained in terms of contagion, imitation, suggestion and learning.

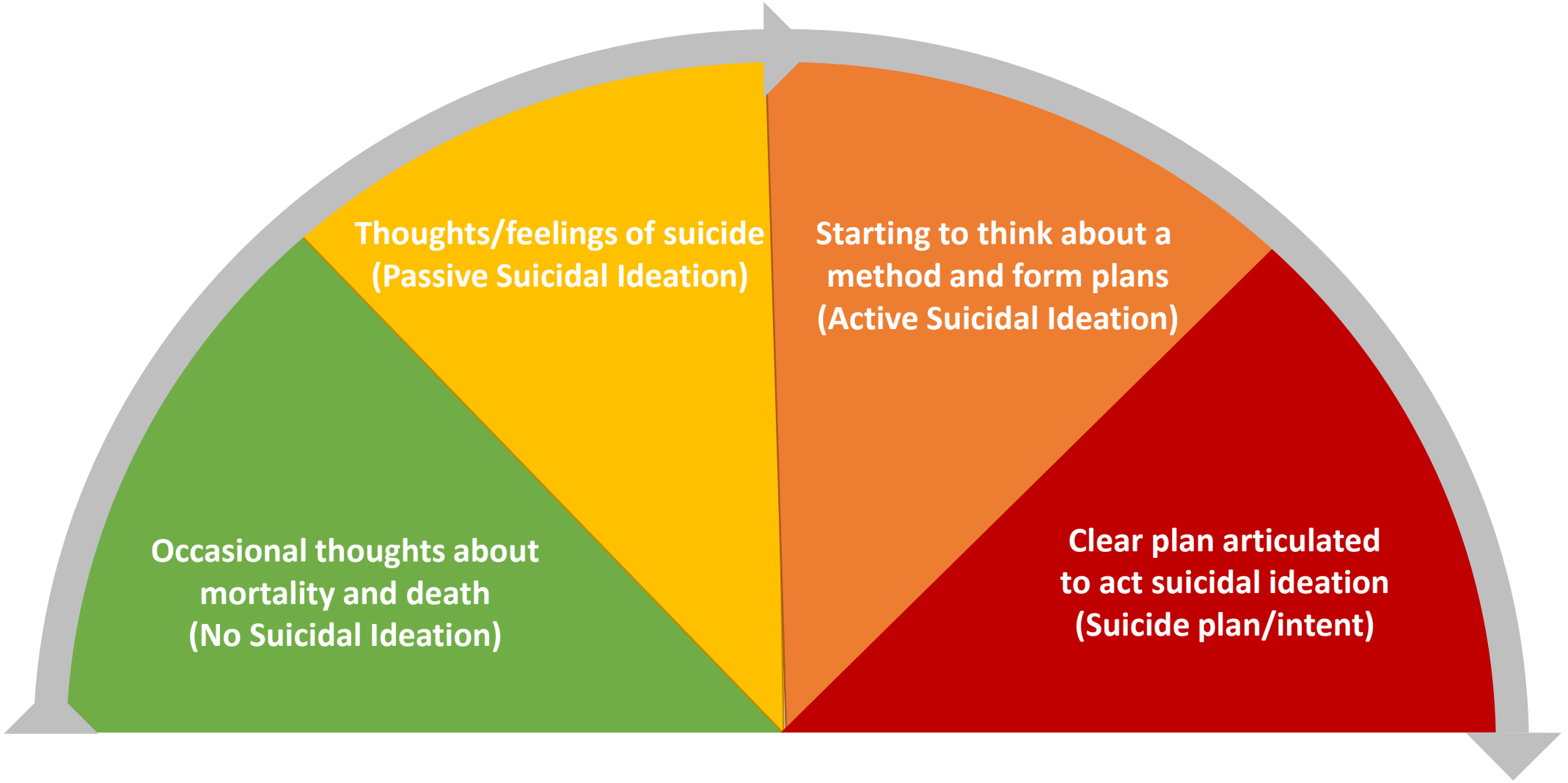
But, what do we mean by suicide?

- **No single definition** - There is no single definitive definition of suicide.

- **Intentionality** - It is really difficult to effectively determine if many deaths are suicide or not. Intentionality of action is very complex. Coroner's courts must use the legal threshold of 'beyond reasonable doubt' to reach a suicide verdict. Many open verdicts, accidental deaths, death by misadventure and narrative verdicts might be *probable* suicide. ICD-10 codes are often used too.

- **Assisted dying** - Further to this we have concepts such as assisted suicide/dying (or euthanasia) that can be considered differently to other suicides.

Suicidality as a spectrum



Multiple attempts

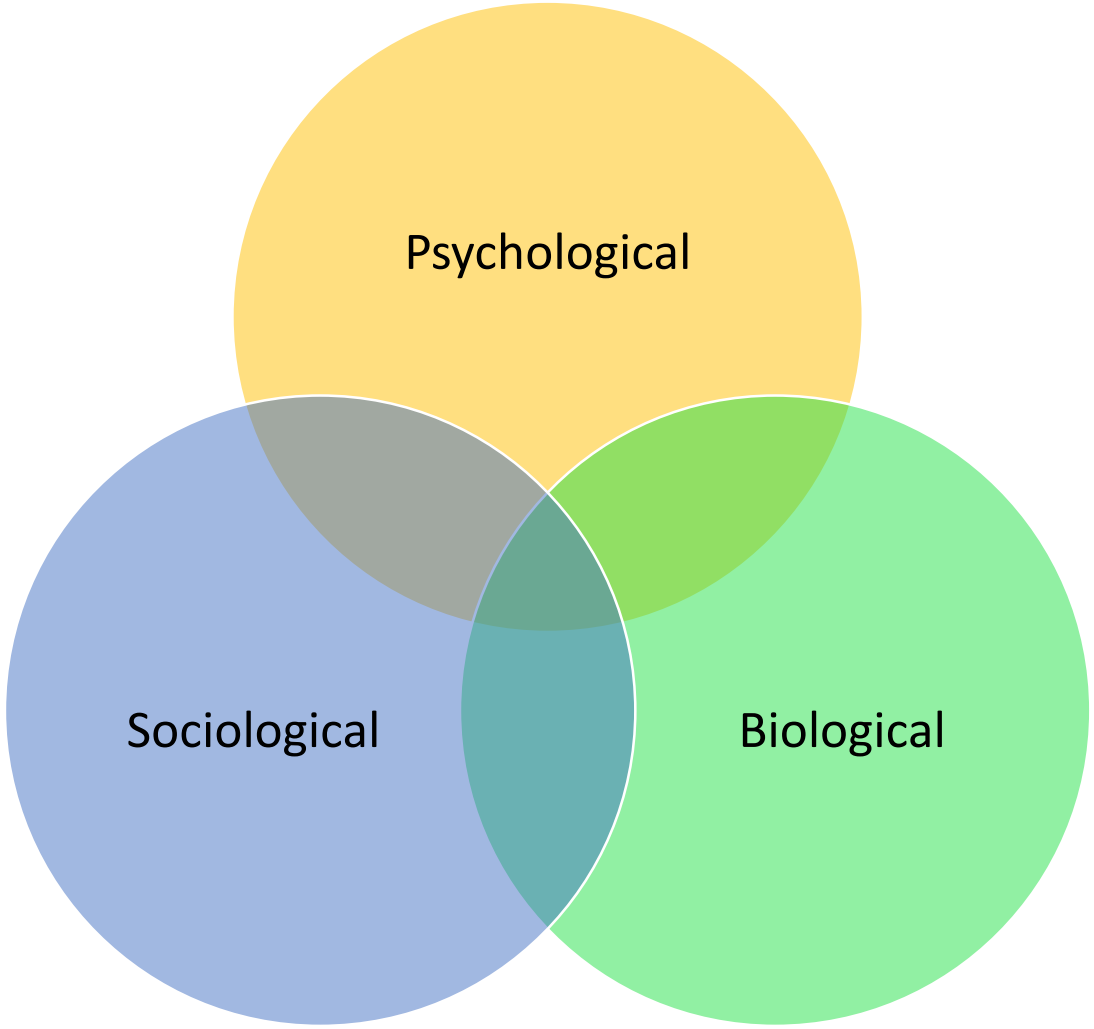
- People often do not completed on the first attempt. Mann et al. (2005) suggested that those completing the act of suicide will have made five attempts.

- Practitioner's need to guard against notions of ‘attention seeking’ behaviour

- This is also linked to self-harm and parasuicide (we’ll talk about these in a bit)

Previous attempts heighten risk! There is a myth that they decrease it, this is untrue

Explanations of suicide



What factors do you think are related to suicide?

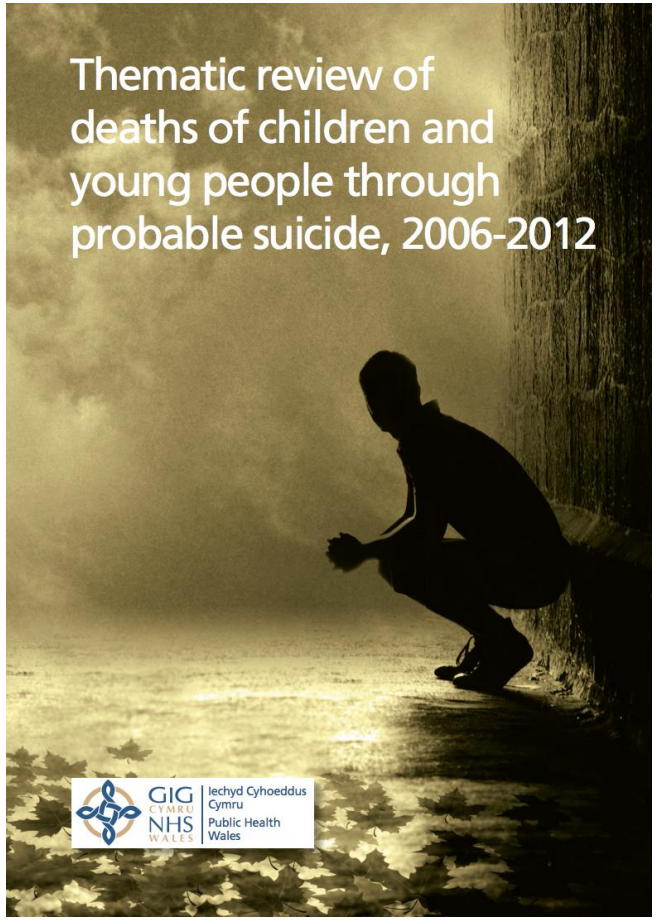
Specific risk factors for young people

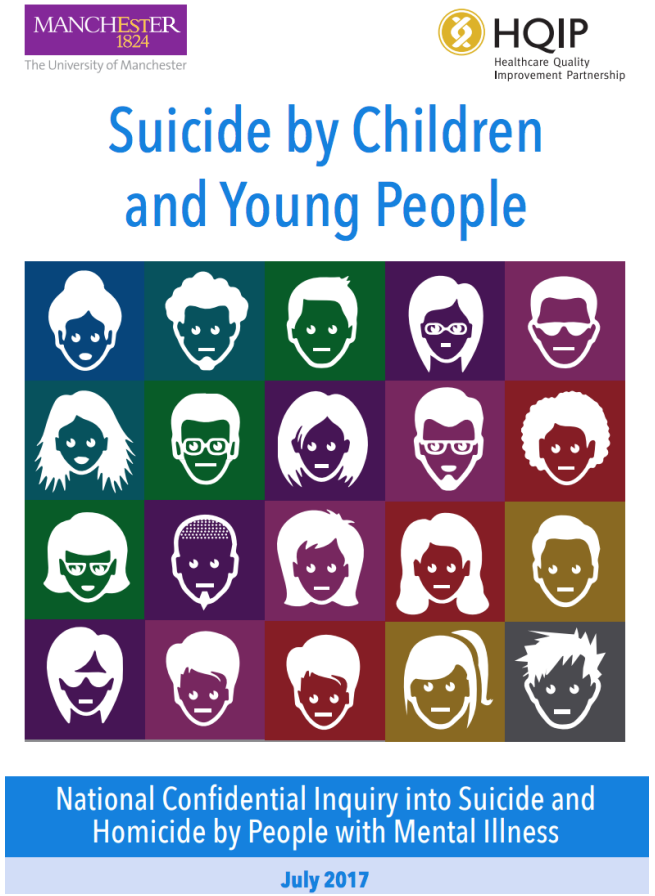
- Family factors such as mental illness
- Abuse and neglect
- Bereavement and experience of suicide
- Bullying
- Suicide-related internet use
- Social isolation and withdrawal
- Academic pressures, especially related to exams
- Physical health conditions that may have social impact
- Alcohol and illicit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

- **Adverse Childhood Experiences (ACEs)**
- **Looked After and Accommodated Children (LAC)**
- **Special Educational Needs (SEN)**

(NCIHS 2017:4)

Two useful reports





Self-harm and suicide

Deliberate Self-Harm (or Non-Suicidal Self-Injury – NSSI) is associated with increased risk of suicide. HOWEVER, not all those who self-harm do so with the intention/desire to die.

A term you might often seen in the literature: *Parasuicide* – This is a self-injurious act that appears to be a suicide but where the intention is not death.

The risk here is that practitioners: (i) assume that there is a straightforward relationship; and/or (ii) do not look at the wider context of service users.

Mental disorders and substance misuse

- Up to 90% of those taking their lives are likely to have some form of mental disorder (Cavanagh et al., 2003). Some mental disorders are at particularly elevated risk:
  - Borderline Personality Disorders
  - Depression
  - Schizophrenia

- Consumption of alcohol and/or controlled substances increase the risk of suicide. Current concerns raised by colleagues in Cardiff about the availability of cocaine.

Suicide by profession

- Some professions have higher rates of suicide than other. Farmers, vets and medical practitioners are at particularly elevated risk of suicide. This is due to them have access to lethal means.

- For farmers the loss of their profession is often linked to loss of identity, community standing, a link their past, income and their homes. It is also a male dominated profession. Brexit represents a risk to the current system of farming subsidies (Glastir scheme). This also raises the risk of an increase in suicide amongst farmers.

Role of the media

Werther effect	Papageno effect
Copycat suicides that result from accounts or depictions of a suicide. Names after Goethe's novel *The Sorrows of Young Werther* (1774). Media reporting of suicides needs to be carefully thought through.	This is a reduction in suicide due to accounts or depictions of suicide. It is less common that Werther effect but acknowledges that the media has an important role to play in preventing suicides.

Social media

Research on this topic is still in its infancy. This said, the NCIHS (2017) in their review of suicides in children and young people noted that:

- 26% of deaths had some element of social media use
- Accessing information about suicide was common and hard to guard against
- Some cases included instance of bullying via social media
- Young people will contact peers about suicidality on social media
- ‘Farewell’ messages can be sent on social media

Method/means of suicide

- Poisoning or overdoses
  - Controlled substances
  - Legal substances
  - Pesticides, herbicides, household products, industrial chemicals, etc.
- Ingesting objects
- Cutting/stabbing self
- Deliberately crashing a vehicle
- Shooting self
- Burning
- Jumping from height
- Hanging/asphyxiation
  - Charcoal
- Drowning
- ‘Death by cop’ (more for the US)

The method selected is unique to each individual. However, issues such as gender, culture and the availability of means (more on this later).

How do we prevent suicide?

Assessing suicide

- There is no reliable way to predict suicide. Scales, measures and tools are ineffective at predicting future suicides

- Contemporary NICE guidance (2011) advises that there should be a psycho-social assessment after any attempted suicide/serious self-harming incidents. These should be person-centred and explore the specific needs of the individual.

- Practitioners need to be trained to understand suicide to make informed assessments.

The legal framework

- Suicide Act 1961
  - Removed common law concepts of suicide as a criminal offence
  - Makes it illegal to assist or promote suicide
- Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (Wales) Measure 2010
  - Primary mental health provision and referral back into Secondary services
  - Care and Treatment Plans
- Social Services and Well-being (Wales) Act 2014
  - Section 119 (formerly Section 25 Children Act 1989 – identical wording)

Prevention strategies

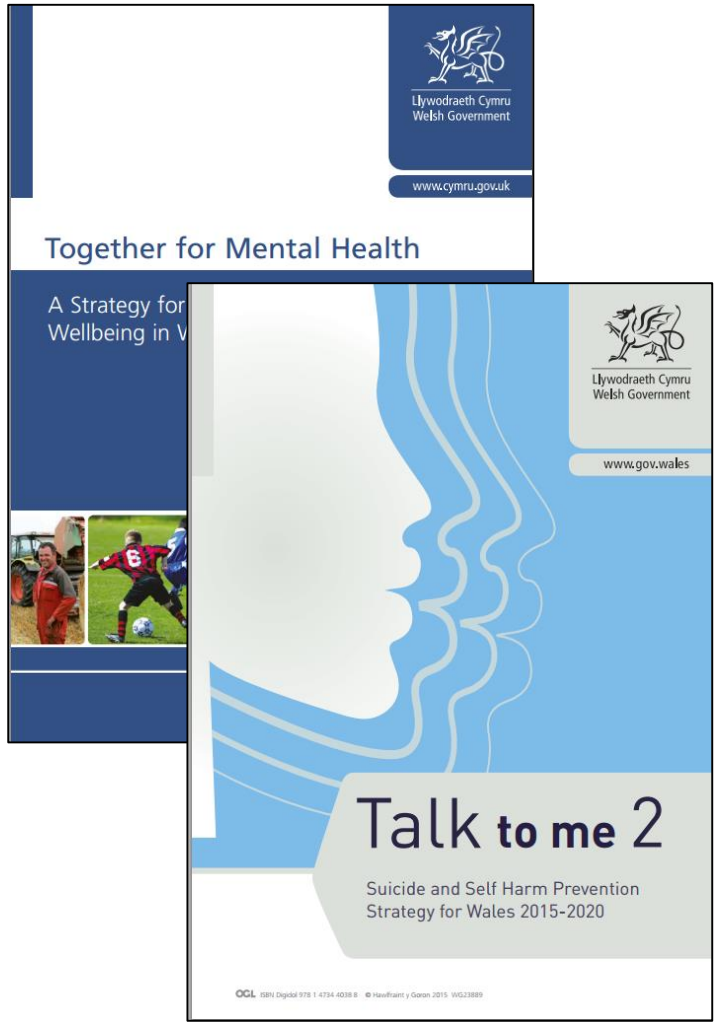
National and regional strategies are can help with:

1) Identifying and monitoring suicide

2) Service delivery

3) Good practice guidance

4) Identify/recommend training



Findings from the thematic analysis

1) Access to means - Hanging account for all bar one death. Preventing access to means is not possible and education about this method is potentially risky

2) Risk factors - Adverse life experiences; Children who are looked after; Special Educational Needs (SEN) and Additional Learning Needs (ALN); Chaotic and transient family backgrounds; Mental disorders, self-harm, substance misuse and criminal/deviant behaviour

3) The role of professionals and services - Mental health services and partner agencies; Role of non-statutory services; PRUDiC process and adults; Postvention support (including support for professionals)

4) Young males - Relationship breakdown; Aggressive and impulsive behaviours.

Reducing access to means

This can be highly effective in preventing deaths. Examples of this include:

- Changes to built environment
- Restricted access to medication and other substances
- Restricted access to firearms

Contact with services

- In Wales between 2004-14 only 23% (*n*=799) of those completing the act were classed as patient suicide. That is to say that they had had contact with mental health services in the 12 months prior to their death. Of these patient suicides, 47% had last had contact with services in the seven days before their death (NCIHS, 2016)

- We need to work with third sector partners and universal services

- Transitions are a period of heightened risk (LAC, CAMHS and AMHS)

Public awareness and educational campaigns

- 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.

Psychological and pharmacological support

- Psychological interventions
  - Limited evidence specifically looking at their effectiveness amongst children and young people
  - Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), problem solving and group therapies have varying levels of effectiveness

- Pharmacological interventions
  - Anti-depressants and mood stabilisers are generally effective
  - The use of certain drugs (i.e. Selective Serotonin Reuptake Inhibitors (SSRIs)) has been queried amongst children and young people

Postvention

with any death, those left behind will mourn the loss of their loved one, yet with suicide this mourning is often compounded by a deceptively simple one word question, *why*?

Those who have been bereaved by suicide are at elevated risk of suicide themselves.

Two useful resources:

1) Help is at hand (Public Health Wales, 2013)
2) Support after a suicide: A guide to providing local services (Public Health England, 2016)

Recommendations from the research

Recommendations (Part 1)

- **Training and support**
  - Specialist suicide prevention training (safeTALK, ASIST and/or Mental Health First Aid) for all staff across agencies. This needs to be sustainable.
  - Integrated support – Role of third sectors and Information Advice and Assistance (IAA).
  - Therapeutic alignment is needed for holistic working

- **Access to help and support**
  - Clear eligibility criteria for mental health services
  - Directing/signposting to wider support services
  - Clarity in therapies being provided (essential for therapeutic alignment)
  - Transitions between services (CAMHS to ADMHS and children in care moving to independence)

Recommendations (Part 2)

- **Monitoring and review**
  - Recording cause of deaths across services
  - Responses to probable suicides in young adults
  - Bereavement support for staff
  - Bereavement support for families (*Help is at hand* - Public Health Wales, 2013)

Training and resources

Recommended training

However, these are primarily about crisis intervention. Working with people in the longer term is complex. The specific needs and circumstance of each individual will require a tailored approach

safeTALK

Applied Suicide Intervention Skills Training (ASIST)

Recommended resources

- British Psychological Society. 2017. *Position Statement: Understanding and* *Psychological Perspective.* Available at: https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20Files/Understanding%20and%20preventing%20suicide%20-%2...tive.pdf (Accessed 25.09.17)
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These can be seen on pages 10 and 11 (10-12 Welsh language version) of the concise repot

Summary

Summary

There is no single cause, or subsequently solution to, suicides in children and young adults. However, this does not mean we should not strive to prevent future deaths. Training and awareness raising can aid in identifying and responding to suicidal ideation and behaviours.

Preventing suicide necessitates many skills that we would consider good practice. A person-centred approach, clear communication and effective transitions would all seem to be things we should be aiming for in the course of our everyday work.

Any changes to the way we work need to be both realistic and sustainable.

Acknowledgements 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 can strive to reduce future deaths.

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

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