Suicide Prevention and Postvention
Special Interest Day
Tuesday 26th May 2015, Royal College of Psychiatrists, London

What works and what may not work

Keith Hawton
<table>
<thead>
<tr>
<th></th>
<th>Number of deaths per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>England and Wales</td>
<td>&gt; 5000 (including open verdicts) M:F ~ 3:1</td>
</tr>
<tr>
<td>Worldwide</td>
<td>~ 850,000 – 1 million</td>
</tr>
</tbody>
</table>
Preventing suicide in England
A cross-government outcomes strategy to save lives

Launched
September 10th 2012
World Suicide Prevention Day
Suicide prevention

High risk group strategies

Population strategies
Preventing suicide in England

Areas for action

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by a suicide
5. Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
People with mental health problems under the care of psychiatric services
National Confidential Inquiry data
England 2000-2010

• General population suicide deaths: 49,532

• Individuals in contact with mental health services in previous 12 months: 13,390 (27%)
What works?

National policies and recommendations

• Removal of ligature points on inpatient units

Safety First, 2001
12 Steps to a Safer Service
In-patient suicide

(Kapur et al. Psychological Medicine 2012)
In-patient and post discharge suicide

(Kapur et al. Psychological Medicine 2012)
What works?

National policies and recommendations

- Removal of ligature points in inpatient units
- Assertive outreach
- 24-hour crisis team
- 7-day follow-up
- Non-compliance
- Dual diagnosis
- Criminal justice information sharing
- Multi-disciplinary review
- Training in suicide risk management

Safety First, 2001
12 Steps to a Safer Service
Questions

• Do mental health services implement policies?

• Do they make a difference?
Do policies make a difference?

Suicide rate per 100,000

* = significant difference p<0.05

(While et al. Lancet, 2012)
Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006

(While et al., 2012)

Reduced suicide rates were associated with:

• Provision of 24-hour crisis care
• Local policies on patients with dual diagnoses
• Multidisciplinary review after suicide

Services that did not implement recommendations had little reduction in suicides
Role of medication in prevention
Lithium in the prevention of suicide in mood disorders: updated systematic review and meta-analysis

Andrea Cipriani 

Keith Hawton

Sarah Stockton

John R Geddes

1Department of Public Health and Community Medicine, Section of Psychiatry, University of Verona, Verona, Italy; 2Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK
Lithium versus placebo: suicides
### Lithium versus placebo: all deaths

<table>
<thead>
<tr>
<th>Study</th>
<th>No of events/total</th>
<th>Peto odds ratio Fixed (95% CI)</th>
<th>Weight (%)</th>
<th>Peto odds ratio Fixed (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Versus placebo</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bauer 2000</td>
<td>0/14</td>
<td>0.14 (0.00 to 7.31)</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Coppen 1971</td>
<td>0/28</td>
<td>0.16 (0.02 to 1.66)</td>
<td>15.5</td>
<td></td>
</tr>
<tr>
<td>Dorus 1989</td>
<td>0/89</td>
<td>0.12 (0.00 to 6.28)</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Hardy 1997</td>
<td>1/6</td>
<td>7.39 (0.15 to 372.38)</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Lauterbach 2008</td>
<td>0/84</td>
<td>0.13 (0.01 to 1.27)</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>Prien 1973a</td>
<td>1/45</td>
<td>0.43 (0.04 to 4.32)</td>
<td>15.8</td>
<td></td>
</tr>
<tr>
<td>Prien 1973b</td>
<td>1/101</td>
<td>0.53 (0.05 to 5.11)</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>Wilkinson 2002</td>
<td>2/25</td>
<td>0.96 (0.13 to 7.25)</td>
<td>20.3</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>5/392</td>
<td>0.38 (0.15 to 0.95)</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Test for heterogeneity: $\chi^2=4.99$, df=7, $P=0.66$, $I^2=0\%$

Test for overall effect: $z=2.06$, $P=0.04$
Antidepressants and suicide prevention

- **Adolescents and young people up to 25 years**: Associated with an increase in suicidal ideation (and ?behaviour)

- **Adults**: No effect on suicidal behaviour

- **Older adults**: Associated with decrease in suicides
Risk assessment
SELF-HARM

THE NICE GUIDELINE ON LONGER-TERM MANAGEMENT

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH
Services and aftercare for self-harm patients

- Services for self-harm patients in all general hospitals
- All staff should be properly trained and supervised
- All self-harm patients should receive psychosocial assessment (including of needs and risk)
- **Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm**
- **Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged**
The sad truth about the SADPERSONS Scale: an evaluation of its clinical utility in self-harm patients

Kate Saunders, 1 Fiona Brand, 2 Karen Lascelles, 2 Keith Hawton 1

ABSTRACT

Background The SADPERSONS Scale is commonly used as a screening tool for suicide risk in those who have self-harmed. It is also used to determine psychiatric treatment needs in those presenting to emergency departments. To date, there have been relatively few studies exploring the utility of SADPERSONS in this context.

Objectives To determine whether the SADPERSONS Scale accurately predicts psychiatric hospital admission, psychiatric aftercare and repetition of self-harm at presentation to the emergency department following self-harm.

Methods SADPERSONS scores were recorded for 126 consecutive admissions to a general hospital emergency department. Clinical management outcomes following assessment were recorded, including psychiatric hospital admission, community psychiatric aftercare and repetition of self-harm in the following 6 months.

Results Psychiatric hospital admission was required in five cases (4.0%) and community psychiatric aftercare in 70 (55.5%). 31 patients (24.6%) repeated self-harm. While the specificity of the SADPERSONS scores was greater than 90% for all outcomes, sensitivity for admission was only 2.0%, for community aftercare was 5.8% and for repetition of self-harm in the following 6 months was just 6.6%.

Conclusions For the purposes of suicide prevention, a low false negative rate is essential. SADPERSONS failed to identify the majority of those either requiring psychiatric admission or community psychiatric aftercare, or to predict repetition of self-harm. The scale should not be used to screen self-harm patients presenting to general hospitals. Greater emphasis should be placed on clinical assessment which takes account of the individual and dynamic nature of risk assessment.
A scale developed in 1983 by Patterson et al in Canada for teaching medical students about assessment of suicide risk

Based on the 10 major risk factors for suicide:

- **S**ex (Male)
- **A**ge (<19 or >45)
- **D**epression
- **P**revious attempts
- **E**thanol abuse
- **R**ational thinking loss
- **S**ocial supports lacking
- **O**rganised plan
- **N**o spouse
- **S**ickness
**SADPERSONS**

Scoring:
1 point for each factor

0 = very low risk    10 = very high risk
0–2 – send home with follow up
3–4 – close follow up; consider hospitalisation
5–6 – strongly consider hospitalisation
7–10 – hospitalise
## Outcomes

<table>
<thead>
<tr>
<th></th>
<th>SADPERSONS score &lt; 7</th>
<th>SADPERSONS score ≥7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to secondary care (N=69)</td>
<td>65 (94.2%)</td>
<td>4 (5.8%)</td>
</tr>
<tr>
<td>Psychiatric inpatient care (N=5)</td>
<td>4 (80%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Repetition of self-harm at 6 months (N=30)</td>
<td>28 (93.3%)</td>
<td>2 (6.7%)</td>
</tr>
</tbody>
</table>
Put another way......

SADPERSONS missed:

- 65/70 referrals to 2º care
- 4/5 admissions to psychiatric hospital
- 28/31 who repeated SH @6/12
Focus on risk reduction rather than just risk assessment

- Risk prediction probably only valid in short term
- Risk reduction for all patients e.g.
  - crisis plans
  - involvement of family members etc.
  - restriction of access to means for suicidal act
Restriction of access to suicide methods
Simplistic model of some causes of fatal and non-fatal suicidal behaviour

**GENETIC & BIOLOGICAL FACTORS**
- Psychological factors (e.g. pessimism, aggression, impulsivity)

**PSYCHOLOGICAL FACTORS**
- Psychological distress
- Hopelessness

**NEGATIVE LIFE EVENTS + SOCIAL PROBLEMS**

**EXPOSURE TO SUICIDE/SELF-HARM**
- Incl. media influences

**AVAILABILITY OF METHOD**
- Method likely to be lethal
- Method unlikely to be lethal

**OUTCOME**
- Suicide
- Self-harm
Restriction of Access to Suicide Methods

What works?

Smaller packs of paracetamol
The new UK legislation – September 16th, 1998
(paracetamol, salicylates and their compounds sold over the counter)

![Bar chart showing the number of tablets available before and after legislation.]

- **Pharmacies**
  - Before legislation: 100 tablets
  - After legislation: 32 tablets

- **Other outlets**
  - Before legislation: 24 tablets
  - After legislation: 16 tablets

Legend:
- \( \text{Before legislation} \)
- \( \text{After legislation} \)
Suicide and open verdict deaths involving paracetamol in people aged 10 years and over in England and Wales

(Hawton et al. 2013)
Deaths involving paracetamol
October 1998-2009

- 43% fewer suicides & open conditions: 765 fewer deaths
- 42% fewer suicides, open & accidental conditions: 990 fewer deaths
Restriction of Access to Suicide Methods
What works?

- Smaller packs of paracetamol
- Withdrawal of co-proxamol
Co-proxamol

- Was involved in 20% of all poisoning suicides in UK
- 5% of all suicides
- **2003–2004** Medicines and Healthcare products Regulatory Agency (MHRA) reviews efficacy and safety profile
- **2005** (January) Committee on Safety of Medicines announces withdrawal in UK
  - **2005-2007** No new patients to be prescribed co-proxamol
  - **2008** Full withdrawal
Impact of withdrawal of co-proxamol on suicide deaths involving analgesics in England and Wales 1998-2010

(Hawton et al. 2009)
Deaths involving co-proxamol
2005-2010

No significant change in deaths involving other analgesics

- 61% fewer deaths in Suicide & Open
- 62% fewer deaths in Suicide, Open & Accidental

500 fewer deaths
600 fewer deaths
Restriction of Access to Suicide Methods
What works?

- Smaller packs of paracetamol
- Withdrawal of co-proxamol
- Suicide barriers
The Clifton Suspension Bridge

buttresses
Barriers on the Clifton Suspension Bridge
MENTAL HEALTH

The effectiveness of structural interventions at suicide hotspots: a meta-analysis

Jane Pirkis,1* Matthew J Spittal,1 Georgina Cox,2 Jo Robinson,2 Yee Tak Derek Cheung1 and David Studdert1,3

1Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, University of Melbourne, Melbourne, Australia, 2Orygen Youth Health Research Centre, Centre for Youth Mental Health, University of Melbourne, Melbourne, Australia and 3Melbourne Law School, University of Melbourne, Melbourne, Australia

*Corresponding author. Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, University of Melbourne, Melbourne, Victoria 3010, Australia. E-mail: j.pirkis@unimelb.edu.au

Accepted 28 January 2013

Background Certain sites have gained notoriety as ‘hotspots’ for suicide by jumping. Structural interventions (e.g. barriers and safety nets) have been installed at some of these sites. Individual studies examining the effectiveness of these interventions have been underpowered.
Structural Interventions at Suicide Hotspots; Systematic review  

- 9 studies
- 86% reduction in jumping suicides at hotspots
- 44% increase in suicides at nearby sites

Net gain 28% reduction in all jumping sites in study cities
Self-harm patients
Repetition of self-harm and suicide in self-harm patients

• > 20% repeat within a year (return to same hospital)
• One in 25 will die by suicide in year after self-harm (>50 x general population risk)
• >50% of people dying by suicide have history of self-harm, 15% presenting to hospital for self-harm in year before death
Assessment at the hospital
Self-harm
The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care
SELF-HARM
THE NICE GUIDELINE ON LONGER-TERM MANAGEMENT
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH
Services and aftercare for self-harm patients

- Services for self-harm patients in all general hospitals
- All staff should be properly trained and supervised
- **All self-harm patients should receive psychosocial assessment (including of needs and risk)**
- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm
- Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged
Does psychosocial assessment reduce repetition of self-harm?  
Multicentre Study of Self-harm in England  
(Kapur et al., PLoS One, 2013)

Hazard ratios for repetition within 1 year (all adjusted)

<table>
<thead>
<tr>
<th></th>
<th>Centre A</th>
<th>Centre B</th>
<th>Centre C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial assessment</td>
<td>0.99</td>
<td>0.59</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td>(0.90 to 1.09)</td>
<td>(0.48 to 0.74)</td>
<td>(0.52 to 0.68)</td>
</tr>
</tbody>
</table>
Care after leaving hospital
Self-harm
The efficacy of psychosocial and pharmacological interventions

Keith Hawton, Katrina Witt, Tatiana Taylor, Ella Arensman, Ellen Townsend, David Gunnell, Philip Hazel, Kees van Heeringen

(Cochrane Collaboration)
Psychological therapy

V

Treatment as usual

17 studies
Brief Psychological Therapy vs. TAU (adults)

Repetition of SH at last follow-up

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Weight</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown 2005</td>
<td>13/45</td>
<td>23/40</td>
<td>5.9%</td>
<td>0.30 [0.12, 0.74]</td>
</tr>
<tr>
<td>Davidson 2014</td>
<td>4/10</td>
<td>4/4</td>
<td>0.5%</td>
<td>0.08 [0.00, 1.81]</td>
</tr>
<tr>
<td>Dubois 1999</td>
<td>8/43</td>
<td>10/41</td>
<td>4.5%</td>
<td>0.71 [0.25, 2.02]</td>
</tr>
<tr>
<td>Evans 1999b</td>
<td>10/18</td>
<td>10/14</td>
<td>2.4%</td>
<td>0.50 [0.11, 2.21]</td>
</tr>
<tr>
<td>Gibbons 1978</td>
<td>27/200</td>
<td>29/200</td>
<td>12.6%</td>
<td>0.92 [0.52, 1.62]</td>
</tr>
<tr>
<td>Guthrie 2001</td>
<td>5/58</td>
<td>17/61</td>
<td>4.3%</td>
<td>0.24 [0.08, 0.71]</td>
</tr>
<tr>
<td>Hatcher 2011</td>
<td>36/253</td>
<td>51/299</td>
<td>16.6%</td>
<td>0.81 [0.51, 1.28]</td>
</tr>
<tr>
<td>Hawton 1987</td>
<td>3/41</td>
<td>6/39</td>
<td>2.4%</td>
<td>0.43 [0.10, 1.87]</td>
</tr>
<tr>
<td>Husain 2014</td>
<td>1/102</td>
<td>1/111</td>
<td>0.7%</td>
<td>1.09 [0.07, 17.64]</td>
</tr>
<tr>
<td>McAuliffe 2014</td>
<td>54/222</td>
<td>50/211</td>
<td>17.7%</td>
<td>1.03 [0.67, 1.61]</td>
</tr>
<tr>
<td>Salkovskis 1990</td>
<td>3/12</td>
<td>4/8</td>
<td>1.5%</td>
<td>0.33 [0.05, 2.24]</td>
</tr>
<tr>
<td>Slee 2008</td>
<td>26/40</td>
<td>21/33</td>
<td>5.3%</td>
<td>1.06 [0.41, 2.78]</td>
</tr>
<tr>
<td>Stewart 2009</td>
<td>3/23</td>
<td>2/9</td>
<td>1.4%</td>
<td>0.53 [0.07, 3.82]</td>
</tr>
<tr>
<td>Tapola 2010</td>
<td>2/9</td>
<td>4/7</td>
<td>1.1%</td>
<td>0.21 [0.02, 1.88]</td>
</tr>
<tr>
<td>Tyrer 2003</td>
<td>84/213</td>
<td>99/217</td>
<td>21.0%</td>
<td>0.78 [0.53, 1.14]</td>
</tr>
<tr>
<td>Wei 2013</td>
<td>1/25</td>
<td>5/27</td>
<td>1.1%</td>
<td>0.18 [0.02, 1.69]</td>
</tr>
<tr>
<td>Weinberg 2006</td>
<td>12/15</td>
<td>14/15</td>
<td>0.9%</td>
<td>0.29 [0.03, 3.12]</td>
</tr>
</tbody>
</table>

Total (95% CI)     | 1329/350  | 1336/100| 100.0% | 0.70 [0.55, 0.88]             |

Total events 292/350

Heterogeneity: Tau² = 0.03; Chi² = 18.50, df = 16 (P = 0.30); I² = 14%

Test for overall effect: Z = 3.02 (P = 0.003)
**Brief Psychological Therapy vs. TAU (adults)**

**Depression scores at last follow-up**

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Treatment Mean</th>
<th>Treatment SD</th>
<th>Treatment Total</th>
<th>Control Mean</th>
<th>Control SD</th>
<th>Control Total</th>
<th>Weight</th>
<th>Std. Mean Difference IV, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown 2005</td>
<td>14.51</td>
<td>12.9</td>
<td>45</td>
<td>18.18</td>
<td>13.75</td>
<td>40</td>
<td>7.6%</td>
<td>-0.27 [-0.70, 0.15]</td>
</tr>
<tr>
<td>Davidson 2014</td>
<td>9.27</td>
<td>5.73</td>
<td>11</td>
<td>16.75</td>
<td>1.5</td>
<td>4</td>
<td>1.6%</td>
<td>-1.39 [-2.67, -0.10]</td>
</tr>
<tr>
<td>Evans 1999b</td>
<td>5.7</td>
<td>5.5</td>
<td>18</td>
<td>10.1</td>
<td>4.1</td>
<td>14</td>
<td>3.9%</td>
<td>-0.87 [-1.60, -0.13]</td>
</tr>
<tr>
<td>Gibbons 1978</td>
<td>10.57</td>
<td>11.39</td>
<td>69</td>
<td>12.62</td>
<td>10.95</td>
<td>71</td>
<td>9.4%</td>
<td>-0.18 [-0.51, 0.15]</td>
</tr>
<tr>
<td>Guthrie 2001</td>
<td>18.5</td>
<td>13.5</td>
<td>47</td>
<td>24</td>
<td>12.5</td>
<td>48</td>
<td>8.0%</td>
<td>-0.42 [-0.83, -0.01]</td>
</tr>
<tr>
<td>Hatcher 2011</td>
<td>5.3</td>
<td>4.7</td>
<td>190</td>
<td>6.2</td>
<td>4.8</td>
<td>232</td>
<td>12.3%</td>
<td>-0.19 [-0.38, 0.00]</td>
</tr>
<tr>
<td>Hawton 1987</td>
<td>6.5</td>
<td>8.26</td>
<td>30</td>
<td>9.6</td>
<td>10.96</td>
<td>35</td>
<td>6.6%</td>
<td>-0.31 [-0.80, 0.18]</td>
</tr>
<tr>
<td>Husain 2014</td>
<td>14.8</td>
<td>17.3</td>
<td>102</td>
<td>19.4</td>
<td>16.9</td>
<td>111</td>
<td>10.7%</td>
<td>-0.27 [-0.54, 0.00]</td>
</tr>
<tr>
<td>McAuliffe 2014</td>
<td>17.3</td>
<td>15.9</td>
<td>128</td>
<td>19.4</td>
<td>17</td>
<td>106</td>
<td>11.0%</td>
<td>-0.13 [-0.39, 0.13]</td>
</tr>
<tr>
<td>Salkovskis 1990</td>
<td>15</td>
<td>6.16</td>
<td>12</td>
<td>23</td>
<td>6.16</td>
<td>8</td>
<td>2.4%</td>
<td>-1.24 [-2.24, -0.25]</td>
</tr>
<tr>
<td>Slee 2008</td>
<td>11.58</td>
<td>12.12</td>
<td>40</td>
<td>29.61</td>
<td>17.51</td>
<td>33</td>
<td>6.4%</td>
<td>-1.21 [-1.71, -0.70]</td>
</tr>
<tr>
<td>Tapolaa 2010</td>
<td>25</td>
<td>13.57</td>
<td>6</td>
<td>24.71</td>
<td>11.87</td>
<td>7</td>
<td>2.1%</td>
<td>0.02 [1.07, 1.11]</td>
</tr>
<tr>
<td>Tyrer 2003</td>
<td>7</td>
<td>5.3</td>
<td>198</td>
<td>7.1</td>
<td>5.2</td>
<td>202</td>
<td>12.3%</td>
<td>-0.02 [-0.22, 0.18]</td>
</tr>
<tr>
<td>Wei 2013</td>
<td>7.26</td>
<td>10.58</td>
<td>25</td>
<td>5.84</td>
<td>8.23</td>
<td>27</td>
<td>5.8%</td>
<td>0.15 [-0.40, 0.69]</td>
</tr>
</tbody>
</table>

**Total (95% CI)**

<table>
<thead>
<tr>
<th></th>
<th>Treatment</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>921</td>
<td>938</td>
</tr>
<tr>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Std. Mean Difference IV, Random, 95% CI</td>
<td>-0.31 [-0.48, -0.14]</td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.05; Chi² = 32.89, df = 13 (P = 0.002); I² = 60%

Test for overall effect: Z = 3.63 (P = 0.0003)
Brief Psychological Therapy vs. TAU (adults)

Hopelessness scores at last follow-up

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Treatment Mean</th>
<th>SD</th>
<th>Total</th>
<th>Control Mean</th>
<th>SD</th>
<th>Total</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown 2005</td>
<td>6.07</td>
<td>5.28</td>
<td>45</td>
<td>7.24</td>
<td>6.35</td>
<td>40</td>
<td>14.1%</td>
<td>-0.20</td>
<td>[-0.63, 0.23]</td>
</tr>
<tr>
<td>Hatcher 2011</td>
<td>5.8</td>
<td>5.8</td>
<td>189</td>
<td>7.2</td>
<td>6.4</td>
<td>229</td>
<td>27.9%</td>
<td>-0.23</td>
<td>[-0.42, -0.03]</td>
</tr>
<tr>
<td>Husain 2014</td>
<td>7.5</td>
<td>8.8</td>
<td>102</td>
<td>11.2</td>
<td>9.1</td>
<td>111</td>
<td>22.4%</td>
<td>-0.41</td>
<td>[-0.68, -0.14]</td>
</tr>
<tr>
<td>McAuliffe 2014</td>
<td>6.8</td>
<td>6.3</td>
<td>128</td>
<td>7.1</td>
<td>6.1</td>
<td>106</td>
<td>23.4%</td>
<td>-0.05</td>
<td>[-0.31, 0.21]</td>
</tr>
<tr>
<td>Patsiokas 1985</td>
<td>3.3</td>
<td>2.34</td>
<td>10</td>
<td>9</td>
<td>7.8</td>
<td>5</td>
<td>2.8%</td>
<td>-1.13</td>
<td>[-2.30, 0.04]</td>
</tr>
<tr>
<td>Salkovskis 1990</td>
<td>6.75</td>
<td>2.3</td>
<td>12</td>
<td>10</td>
<td>2.3</td>
<td>8</td>
<td>3.7%</td>
<td>-1.35</td>
<td>[-2.36, -0.34]</td>
</tr>
<tr>
<td>Stewart 2009</td>
<td>4.35</td>
<td>4.22</td>
<td>23</td>
<td>7.56</td>
<td>8.53</td>
<td>9</td>
<td>5.7%</td>
<td>-0.55</td>
<td>[-1.33, 0.23]</td>
</tr>
</tbody>
</table>

Total (95% CI) 509 508 100.0% -0.31 [-0.51, -0.10]

Heterogeneity: Tau² = 0.03; Chi² = 11.13, df = 6 (P = 0.08); I² = 46%
Test for overall effect: Z = 2.96 (P = 0.003)
Brief Psychological Therapy vs. TAU (adults)

Suicidal ideation scores at last follow-up

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Experimental Mean</th>
<th>SD</th>
<th>Total</th>
<th>Control Mean</th>
<th>SD</th>
<th>Total</th>
<th>Weight</th>
<th>Std. Mean Difference IV, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davidson 2014</td>
<td>12.36</td>
<td>12.48</td>
<td>11</td>
<td>26.5</td>
<td>1.92</td>
<td>4</td>
<td>2.1%</td>
<td>-1.21 [-2.46, 0.04]</td>
</tr>
<tr>
<td>Guthrie 2001</td>
<td>8.3</td>
<td>8.6</td>
<td>47</td>
<td>12.1</td>
<td>10.4</td>
<td>48</td>
<td>13.5%</td>
<td>-0.39 [-0.80, 0.01]</td>
</tr>
<tr>
<td>Hatcher 2011</td>
<td>3.7</td>
<td>6.7</td>
<td>187</td>
<td>4.8</td>
<td>7.4</td>
<td>231</td>
<td>26.4%</td>
<td>-0.15 [-0.35, 0.04]</td>
</tr>
<tr>
<td>Husain 2014</td>
<td>7.8</td>
<td>10.7</td>
<td>102</td>
<td>11.3</td>
<td>10.4</td>
<td>111</td>
<td>20.8%</td>
<td>-0.33 [-0.60, -0.06]</td>
</tr>
<tr>
<td>McAuliffe 2014</td>
<td>4.7</td>
<td>8.9</td>
<td>171</td>
<td>4.9</td>
<td>8.9</td>
<td>142</td>
<td>24.2%</td>
<td>-0.02 [-0.24, 0.20]</td>
</tr>
<tr>
<td>Patsiokas 1985</td>
<td>5.1</td>
<td>5.29</td>
<td>10</td>
<td>8.6</td>
<td>9.2</td>
<td>5</td>
<td>2.7%</td>
<td>-0.49 [-1.58, 0.60]</td>
</tr>
<tr>
<td>Stewart 2009</td>
<td>1.91</td>
<td>4.07</td>
<td>23</td>
<td>10.11</td>
<td>12.67</td>
<td>9</td>
<td>4.6%</td>
<td>-1.08 [-1.90, -0.26]</td>
</tr>
<tr>
<td>Weinberg 2006</td>
<td>37.96</td>
<td>18.68</td>
<td>15</td>
<td>45.69</td>
<td>14.38</td>
<td>15</td>
<td>5.6%</td>
<td>-0.45 [-1.18, 0.27]</td>
</tr>
</tbody>
</table>

Total (95% CI) 566 565 100.0% -0.28 [-0.47, -0.09]

Heterogeneity: Tau² = 0.02; Chi² = 12.04, df = 7 (P = 0.10); I² = 42%

Test for overall effect: Z = 2.95 (P = 0.003)
Brief Psychological Therapy vs. TAU (adults)

Suicide at last follow-up

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Treatment Events</th>
<th>Control Events</th>
<th>Total</th>
<th>Weight</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown 2005</td>
<td>0</td>
<td>1</td>
<td>60</td>
<td>6.6%</td>
<td>0.33 [0.01, 8.21]</td>
</tr>
<tr>
<td>Davidson 2014</td>
<td>1</td>
<td>0</td>
<td>10</td>
<td>6.0%</td>
<td>1.42 [0.05, 42.22]</td>
</tr>
<tr>
<td>Dubois 1999</td>
<td>0</td>
<td>0</td>
<td>51</td>
<td></td>
<td>Not estimable</td>
</tr>
<tr>
<td>Guthrie 2001</td>
<td>0</td>
<td>0</td>
<td>58</td>
<td></td>
<td>Not estimable</td>
</tr>
<tr>
<td>Hatcher 2011</td>
<td>3</td>
<td>4</td>
<td>253</td>
<td>30.2%</td>
<td>0.89 [0.20, 3.99]</td>
</tr>
<tr>
<td>Hawton 1987</td>
<td>1</td>
<td>0</td>
<td>41</td>
<td>6.6%</td>
<td>2.93 [0.12, 74.00]</td>
</tr>
<tr>
<td>Husain 2014</td>
<td>2</td>
<td>2</td>
<td>102</td>
<td>17.5%</td>
<td>1.09 [0.15, 7.88]</td>
</tr>
<tr>
<td>McAuliffe 2014</td>
<td>1</td>
<td>2</td>
<td>222</td>
<td>11.8%</td>
<td>0.47 [0.04, 5.25]</td>
</tr>
<tr>
<td>Salkovskis 1990</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td></td>
<td>Not estimable</td>
</tr>
<tr>
<td>Slee 2008</td>
<td>0</td>
<td>1</td>
<td>48</td>
<td>6.6%</td>
<td>0.29 [0.01, 7.19]</td>
</tr>
<tr>
<td>Stewart 2009</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td></td>
<td>Not estimable</td>
</tr>
<tr>
<td>Tapola 2010</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td></td>
<td>Not estimable</td>
</tr>
<tr>
<td>Tyrer 2003</td>
<td>1</td>
<td>5</td>
<td>239</td>
<td>14.8%</td>
<td>0.20 [0.02, 1.71]</td>
</tr>
<tr>
<td>Wei 2013</td>
<td>0</td>
<td>0</td>
<td>26</td>
<td></td>
<td>Not estimable</td>
</tr>
<tr>
<td>Weinberg 2006</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td></td>
<td>Not estimable</td>
</tr>
</tbody>
</table>

Total (95% CI) 1169 1185 100.0% 0.66 [0.29, 1.51]

Total events 9 15

Heterogeneity: Tau² = 0.00; Chi² = 3.13, df = 7 (P = 0.87); I² = 0%

Test for overall effect: Z = 0.98 (P = 0.33)
Services and aftercare for self-harm patients

• Services for self-harm patients in all general hospitals

• All staff should be properly trained and supervised

• All self-harm patients should receive psychosocial assessment (including of needs and risk)

• Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm

• Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged

• Psychological therapy can be effective in reducing risk of repetition of self-harm
Suicide Prevention and Postvention
Special Interest Day
Tuesday 26th May 2015, Royal College of Psychiatrists, London

What works and what may not work

Keith Hawton