



Suicide Prevention Programme – Learning Set 1

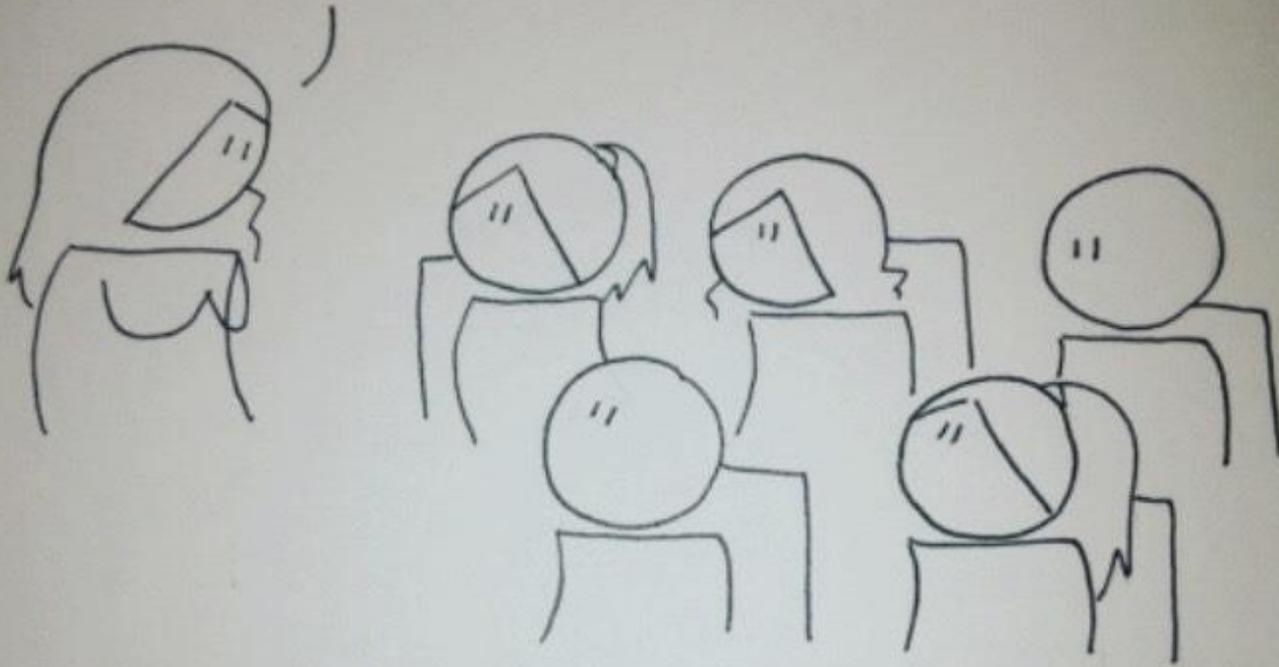
17TH SEPTEMBER 2019

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Introduction

TOM AYERS - DIRECTOR
NATIONAL COLLABORATING
CENTRE FOR MENTAL HEALTH

OK! Quick icebreaker!



Everyone say one thing
they hate about
icebreakers!

Elevator Pitch

- Spend 3 minutes in your STP groups discussing your **top 3** priorities for suicide prevention and the strengths you have that will help you achieve these priorities
- You will then have **1 minute** to pitch your ideas to the whole group

What support is on offer

The NCCMH and NCISH will be offering the following support:

Support	Who receives it
Monthly Clinics	Open to all STPs (including those outside of the programme)
Learning Sets	Wave 1 STPs, Wave 2 STPs and Trailblazer sites
Site Visits	Wave 2 STPs
QI Coach Support	Wave 2 STPs
Life QI platform	Wave 1 and 2 STPs

The Programme Team



Amar Shah
National Quality
Improvement Lead



Helen Smith
Clinical Programme
Director



Tom Ayers
Programme Lead



**Eva Gautam-
Aitken Senior**
Project Manager



**Kaycee
Meads** Project
Manager

Quality Improvement Coaches



Kate Lorrimer



Emily Cannon



Matt Milarski



Saiqa Akhtar

Agenda

Agenda		
10:30 – 11:00	Registration	
11:00 – 11:20	Welcome and introduction to the collaborative	Tom Ayers
11:20 – 11:40	Norfolk and Waveney 12 th Man – a campaign to get men talking about mental health	Nick Little
11:40 – 12:00	NHSE and Suicide Prevention	Tim Kendall
12:00 – 12:40	Self-harm and Suicide Prevention: update on the latest findings <ul style="list-style-type: none"> • Update (15 mins) • Q and A session (25 mins) 	Prof. Louis Appleby
12:45 – 13:10	Lunch	
13:10 – 13:15	Introduction to the afternoon session	Tom Ayers
13:15 – 13:35	Lancashire and South Cumbria Real-time surveillance	
13:35 – 13:55	Mersey Care Self-harm	Dr Cecil Kullu Emma Mullins
13:55 – 14:20	Crowd sourcing for Learning Set 2	QI Coaches
14:20 – 14:30	South West London Trailblazer prevention project aimed at middle-aged men and bereavement support service	Leah O'Donovan
14:30 – 14:55	Coventry and Warwickshire <ul style="list-style-type: none"> • Mindstance (15 mins) • It Takes Balls to Talk update (10 mins) 	Simon Morgan Alex Cotton
14:55 – 15:00	Final comments and close	Tom Ayers

12th Man

NORFOLK AND WAVENEY STP



Nick Little

Director, The Outsiders

Co-creator, 12th Man Campaign





Be the

12th Man



Plenty
of talking



Support
each other



Don't bottle
it up!

Tackle the stigma



12th Man
Cycling Club

WE ARE A



12th man
men & mental health

BARBER SHOP

12th-man.org.uk

HUMAN'S
REVERSE SHOP

RACCOMANDATO DA



12TH  MAN
MENSWEAR

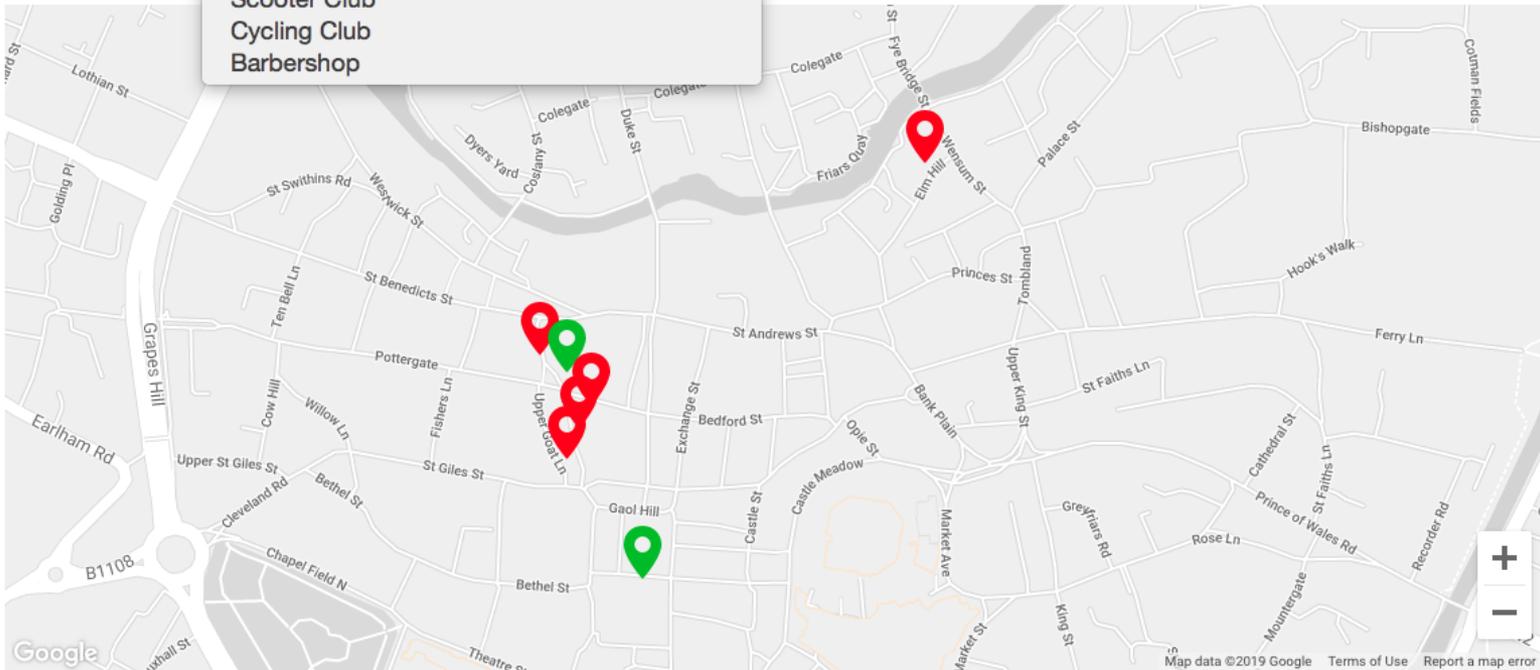




See what's going on in your community

TRADE OR INTEREST

- ✓ All
- Pub
- Scooter Club
- Cycling Club
- Barbershop





The Campaign

Trades

Interests

Training

SOUNDS

FILMS

EVENTS

NEWS

Donate →



12th Man Cycling Club

12th Man Cycling Club is a virtual club for men to affiliate to and raise awareness of mental health.

[Get Support](#) → [Join the Campaign](#) →

x

<https://12th-man.org.uk/the-campaign/get-support> **Talk. Support.**

Find



The Campaign

Trades

Interests

Training

SOUNDS

FILMS

EVENTS

NEWS

Donate →

The latest

News



[CYCLING CLUB](#) | [NEWS](#)

Tue 30th Jul, 2019

New 12th Man Cycling Kit



Event



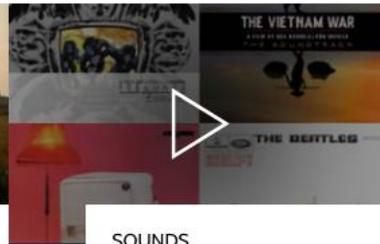
[CYCLING CLUB](#) | [EVENTS](#)

Thu 1st Aug, 2019

Aug 1 12th Man Social Ride



Sound



[SOUNDS](#)

Mon 20th May, 2019

12th Man Playlist



Training



[CYCLING CLUB](#) | [TRAINING](#)

Sat 20th Jul, 2019

Jul 20 Suicide Awareness Training





NEVER MIND THE BOLLOCKS

BETHE

12TH MaN

BE THE
12TH MAN

12TH MAN

12TH MAN

PRODUCT TYPE

T-Shirts (34)

INTERESTS

Barbershop (2)

Cycling (5)

Scooters (24)

RECENTLY VIEWED



Cycling Club Alt T-Shirt

£20.00



Cycling Club Curve Art print

£24.99 – £38.99

Sort by Default Display 30 Products per page



12th Man Barbershop Alt T-Shirt

£20.00



12th Man Barbershop T-Shirt

£20.00



12th Man T-Shirt

£20.00



12th
man

It's a strength
not a weakness



www.12th-man.org.uk

NHSE and Suicide Prevention

TIM KENDALL

NHS Suicide Prevention and Bereavement Support Services

**Prof. Tim Kendall
National Clinical Director for Mental Health**

September 2019

NHS England and NHS Improvement

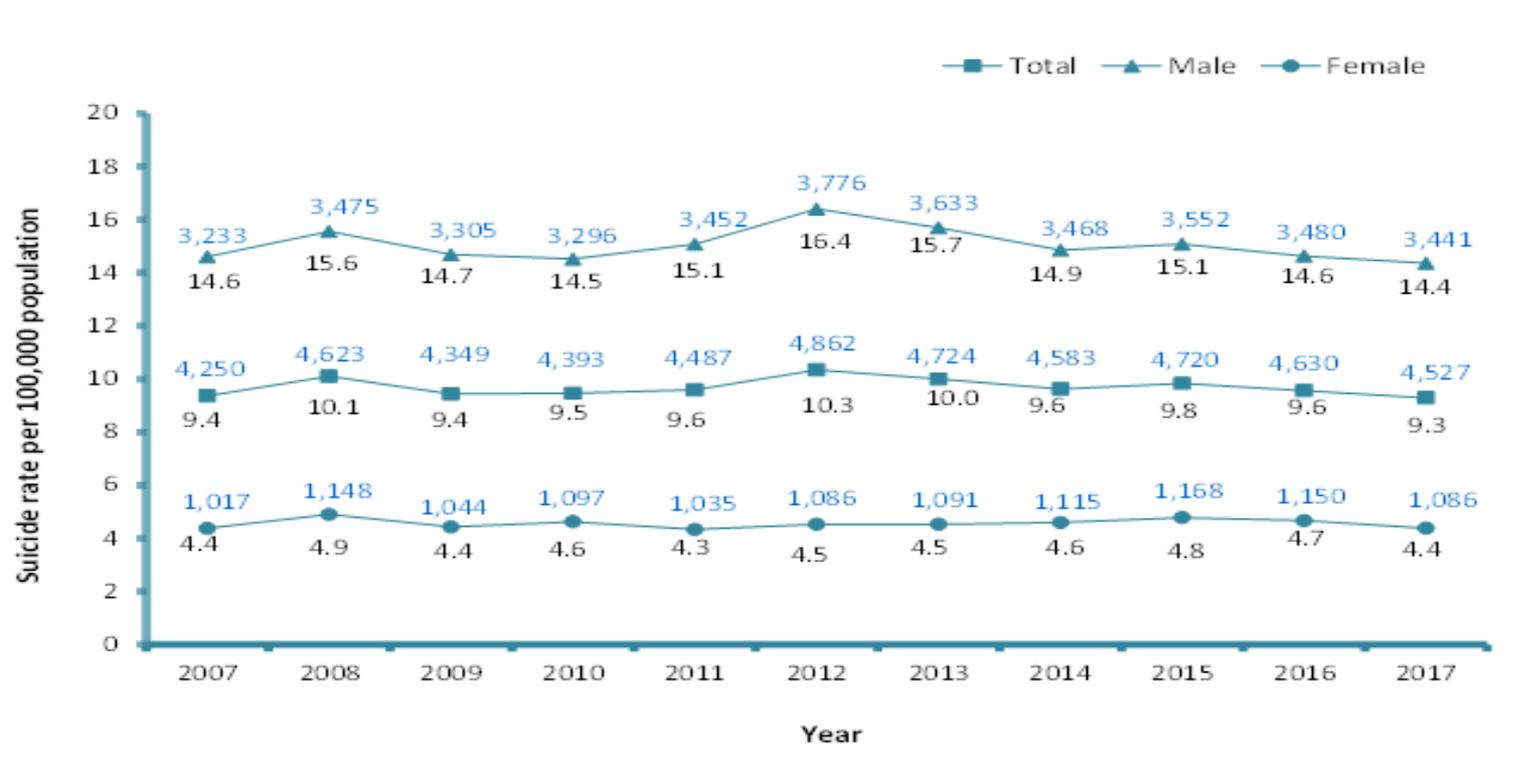


Contents

- I. Data on suicides in England
- II. Policy context
- III. NHS England suicide reduction programme
- IV. Zero suicide ambition

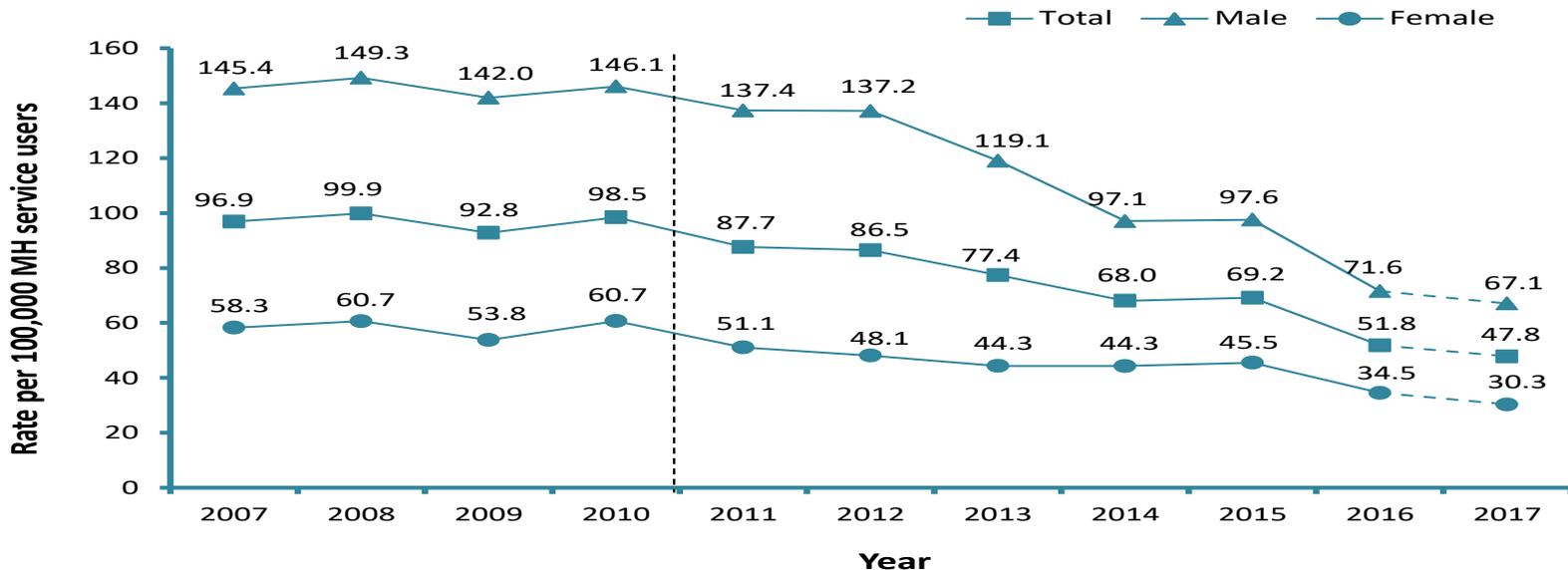
What trends are we seeing in deaths by suicide over the last ten years?

- The pattern of suicide in England population, since 2007 is:
 - a rise in 2008 and 2012
 - lower rates since 2012. The low figures of recent years have been broadly maintained.
- 28% general population suicides are people who had been in contact with mental health services in the 12 months prior to death. This number increased 2007 to 2012 and decreased 2013 – 2014, remaining stable since 2014.



We see different trends relating to patients who have been in contact with mental health services

- The rate of total patient suicides has decreased significantly (51%) from 2011 to in 2017, whilst absolute number of patient suicides has remained stable. The rate is 137.4 in 2011 and 67.1 in 2017.
- Rate and number of suicides in mental health in-patients has reduced, in 2017 it is the lowest recorded figure since 2007.



* 'patient' refers to someone who had been in contact with MH services in the preceding 12 months.

What can we learn about the patients who die by suicide who have used mental health services in England

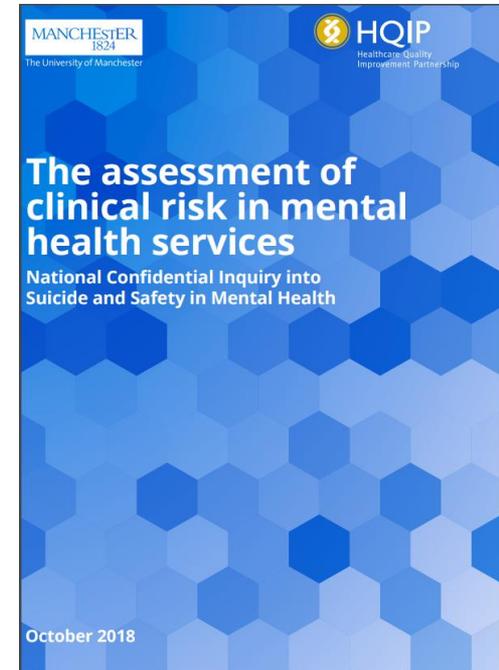
In 2017, the National Confidential Inquiry into Suicide and Safety in Mental Health found in 2017:

- 48% of suicides had, had a last contact with MH services within preceding 7 days of death.
- 23% had missed last contact in previous month.
- 16% were under crisis resolution/home treatment services:
- 7% were inpatients at the time of death.
- 16% of suicides were within 3 months of discharge from ward:
 - number and rate of post-discharge suicides have fallen since a peak in 2011
 - most frequent in the first week, highest number on third day.
- 44% of all young patients under 25 and there was no change over the report period.
- High rates of previous self-harm (66%).
- High rates of alcohol misuse (45%) and drug misuse(34%):
 - suicides in patients with a history of alcohol or drug misuse has fallen since a peak in 2011, but increase seen from 2016 to 2017
- Primary psychiatric diagnoses (in adults): bipolar disorder and depression (44%), schizophrenia (16%) and personality disorder (10%).

Taking a new approach to risk assessment

Big question to ask about risk aversion – have we created the right culture?

- “Risk assessment tools should not be seen as a way of predicting future suicidal behaviour.”
- “Risk is not a number, and risk assessment is not a checklist.”
- “There is a growing consensus that risk tools and scales have little place on their own in the prevention of suicide.”
- “The management of risk should be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone.”
- See [Bolton et al \(2015\)](#), [Chan et al \(2016\)](#), [Quinlivan et al \(2017\)](#)

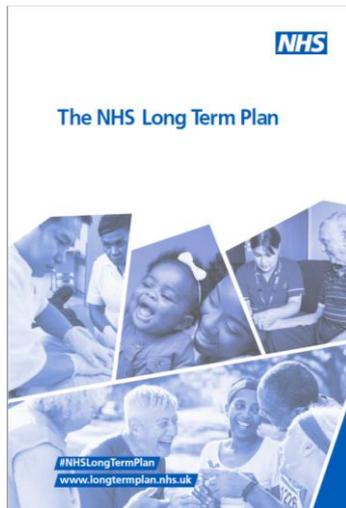
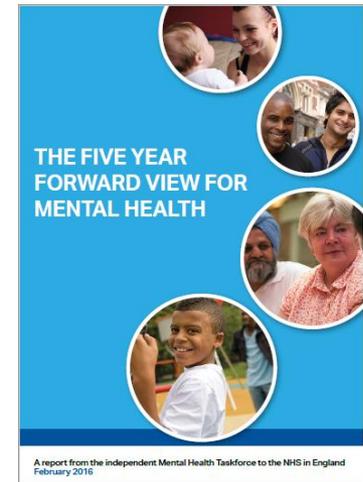


Need a cultural shift towards proactively addressing individual need and focussing on safety instead of myopic focus on risk – which is relatively poorly-understood, dynamic and subjective – as a proxy to determine access and intensity of input

Policy context

Wider investment into mental health

- The Five Year Forward View for Mental Health represents significant investment in a very ambitious national programme.
- Since publication of the plan, spending across the health service has increased in each of the last three years – from £10,979 million in 2015/16 to £12,155 million planned for 2018/19, with further investment expected on top of that during the year.
- The NHS Long Term Plan has built on this with an additional £2.3 billion in ringfenced funding by 2023/24. This will support among other things:



- Significantly **more children and young people from** 0 to 25 years old to access timely and appropriate mental health care. NHS-funded school and college-based Mental Health Support Teams will also be available in at least one fifth of the country by 2023.
- People with **moderate to severe mental illness** will access better quality care across primary and community teams, have **greater choice and control** over the care they receive, and be supported to lead fulfilling lives.
- We will **expand perinatal mental health care** for women who need specialist mental health care during and following pregnancy.
- The NHS will provide a single-point of access and timely, age-appropriate, **universal mental health crisis care** for everyone, accessible via NHS 111.

Suicide reduction policy



Mental Health Five Year Forward View (2016)

- The Five Year Forward View for Mental Health (FYFVMH) represented significant investment in a very ambitious national programme for suicide reduction.
- The FYFVMH ambition for suicide prevention and reduction is that by 2020/21, the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.
- £25 million transformation funding was committed for 2018/19 - 2020/21 (£5m; £10m; £10m) to support its delivery.

NHS Long Term Plan (2019)

- With the publication of the Long Term Plan, the NHS has committed that by 2023/24,
 - The current suicide prevention programme will cover every local area in the country.
 - All systems will have suicide bereavement support services providing timely and appropriate support to families and staff in place
 - This will be financed in a ‘targeted and phased manner’

Funding Type (£ Million – Cash prices)		Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Suicide Reduction and Bereavement Support	Central / Transformation	5	11	12	12	13	9
	CCG baselines	0	0	0	0	0	0
	Total	5	11	12	12	13	9

How are we progressing in England to reduce suicide rates?

- In 2017, there were 4,451 suicides in England and the suicide rate was 9.2 per 100,000 of population.
- **This is a decrease in the number of suicides between 2015 and 2017 of 7.7%, with a 3% fall last year, and shows good progress against meeting the target of a 10 percent reduction.**
- **However, The recent ONS data release shows there were 5,021 suicides registered in England in 2018.**
- This is an increase by 4% in the number of suicides and shows a reversal of progress to date in meeting the MHFYFV target of a 10 percent reduction by 2020/21.

Change in standard of proof

- In England and Wales all deaths caused by suicide are certified by a coroner. In July 2018, the standard of proof used by coroners to determine whether a death was caused by suicide was lowered to the “civil standard” – balance of probabilities – where previously a “criminal standard” was applied – beyond all reasonable doubt.
- It is likely that lowering the standard of proof will result in an increased number of deaths recorded as suicide, possibly creating a discontinuity in our time series. Currently it is not possible to establish whether the higher number of recorded suicide deaths are a result of this change.

NHS England's suicide reduction programme



Funding for local areas

- Over 2018/19 and 2019/20 we have allocated transformation funding to 16 areas with the highest suicide rates.
- Local areas have used the funding for programmes, interventions and local activities that are focussed on self-harm, middle-aged men, primary care and quality improvements in emergency departments and mental health services generally.
- We plan to roll this funding out to all local areas in England by 2023/24.
- National quality improvement programme has been commissioned to support local areas.
- Nationally commissioned evaluation of first group of sites on impact of local programmes.

Trailblazer sites

- In 2019/20 we have funded local areas identified as having good practice or showing innovation, with the focus on male-focussed suicide reduction or self-harm care trailblazers.
- Trailblazers will be asked to support neighbouring areas & provide evaluation for shared learning.

Examples of local services being delivered by areas with high rates of suicide



Area	Key project objectives
Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	Real time alert system; development of primary care database for early intervention; review of self-harm clinical pathway in A&E
Coventry and Warwickshire	Raising awareness amongst vulnerable groups and engaging with community assets; workforce development – needs of emergency responders and MH workforce
Kent and Medway	Kent Universities' Suicide Safer Project; bereavement and postvention support; coroner's audit with qualitative methodologies; CYP suicide prevention training
Bristol, North Somerset and South Gloucestershire	Continuation and expansion of HOPE (liaison worker to support tackling debt and financial issues and psychosocial support); extension of training programme; development of targeted strategy to raise mental health awareness and wellbeing for men.
North East and North Cumbria ICS	Football project targeting middle aged men - work with the two football foundations from the major league clubs within the Northern footprint, Newcastle and Sunderland
Humber, Coast and Vale	Develop targeted engagement campaign and deliver into local STP areas. Audit across STP MH Trusts to ensure compliance with evidence base of 10 steps to safer services and NICE. Promotion of 72 hour follow up after discharge.
Cheshire and Merseyside	Co-produce a suicide prevention intervention for middle-aged men in Cheshire & Merseyside that targets those at risk. To establish a Lived Experience Network that advises and co-produces the self-harm/ suicide prevention programmes, policies and plans such that they are equal partners.
Hampshire and the Isle of Wight	Review self-harm pathway for adults and CYP to improve assessment and identification and pilot and develop an effective model of support and care.

Examples of work underway by trailblazer sites



Area	Key project objectives
West Yorkshire and Harrogate ICS	Establish pathway for men to access support services and promote/ and publicise. Facilitate peer support groups and networks based on Offload programme.
Joined up Care Derbyshire	Suicide Prevention Training in Primary Care; Derbyshire Healthy Workplaces programme in particular with employers in sectors that exhibit higher rates of suicide
Cambridge and Peterborough	Creation of a STOP suicide multi-media information package. Extending and developing a system of learning from real-time suicide surveillance, incorporating learning from communities to focus on prevention in middle aged men.
Buckinghamshire, Oxfordshire, Berkshire West	Develop, implement and evaluate a gold standard evidence based biopsychosocial assessment for self-harm, including safety planning, with accompanying training and supervision, for use in psychiatric liaison teams based in general hospitals.
Somerset	Setting up and maintaining a self-harm register for hospital admissions and extend the data gathering to community-based services.

National Quality Improvement Delivery Programme



The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) and the Royal College of Psychiatrists (RCPsych), with the National Collaborating Centre for Mental Health (NCCMH) have been commissioned to deliver a joint programme of quality improvement support.

Full Intensive Quality Improvement (QI) package. Pre-identified STPs and GMP to receive:

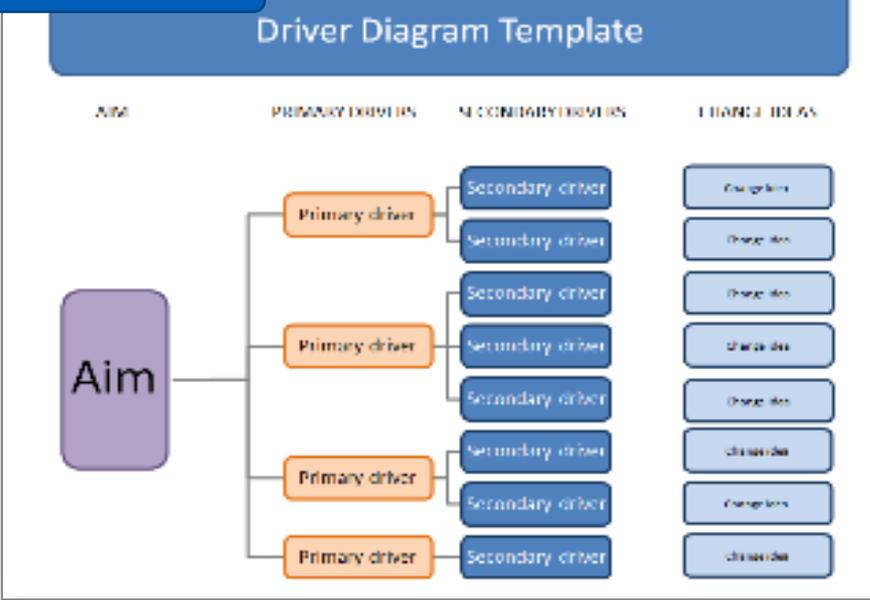
- Support to survey services against established guidelines and recommendations, identify priority areas
- Direct input including visits to present & discuss the evidence behind the "10 ways to improve safety" & other national findings
- Provide bespoke data for each trust as part of a dialogue about their local needs
- Help work up a suicide prevention plan using QI method
- Advise and support trusts with evidence as QI plan goes ahead
- Embed QI methodology to ensure sustained improvements



National evidence from National Confidential Inquiry & emerging reports



QI methodology



Postvention bereavement services



- In 2019/20 NHS England has worked with an expert advisory group to identify a shortlist of areas to be invited to demonstrate fidelity to deliver against national guidance on postvention bereavement services.
- Going forward, we plan to roll out funding for postvention bereavement services across the country.
- We are working with Public Health England to understand how real-time surveillance can be delivered at local, regional and national level.
- Support After Suicide Partnership (SASP) has been commissioned to deliver postvention bereavement implementation support in addition to its central hub of resources.

Examples of local services being delivered

Area	Key project objectives
Nottinghamshire	Development and implementation of an early alert system; access to Harmless BACP accredited psychotherapeutic team.
Leicester, Leicestershire and Rutland	Direct Counselling and practical support - for individuals affected by a death by suicide.
North Central London	Suicide liaison service would offer a 'reach out' support service.
North West London	Proactive contact with the bereaved family within 72 hours of a death, facilitated by Thrive London's Information Sharing Hub.

National zero suicide ambition



- An ambition (not target) for zero suicides for mental health inpatients was announced by the previous Secretary of State in January 2017.
- NHS England and NHS Improvement are supporting all mental health trusts to have zero suicide ambition plans in place.
- The Government has also invested £2million in the Zero Suicide Alliance which is a collaborative led by Mersey Care mental health trust and is improving suicide awareness and training across the NHS and wider communities as well as delivering projects to improve the way NHS organisations learn from suicides.

The screenshot shows the homepage of the Zero Suicide Alliance. At the top left is the logo 'Zero Suicide Alliance' with the tagline 'Because ONE life lost is ONE too many'. To the right, it states '235,362 people have accessed our training' and includes social media icons for Facebook, Twitter, and Instagram. Below this are two orange buttons: 'GET URGENT HELP' and 'GOT 20 MINS? LEARN LIFE SAVING SKILLS TODAY!'. A navigation bar contains links for HOME, ABOUT US, GET INVOLVED, PERSONAL STORIES, OUR CHAMPIONS, NEWS, FAQs, and CONTACT US. The main banner features a woman with long curly hair and the text 'SAVE A LIFE... TAKE THE TRAINING' in large yellow letters. Below the banner is a yellow button that says 'Take our FREE suicide prevention training'. At the bottom, there is a yellow bar with the text 'TAKE OUR ZERO SUICIDE PREVENTION TRAINING TODAY - IT ONLY TAKES 20 MINUTES!!!'. Three smaller images are shown below: a woman with the text 'WHAT IS THE ZERO SUICIDE ALLIANCE?', a man with the text 'GET INVOLVED TODAY... SIGN UP FOR OUR LATEST NEWS', and a man with the text 'READ THE PERSONAL STORIES BEHIND THE STATS'.

Thank you

Any questions?

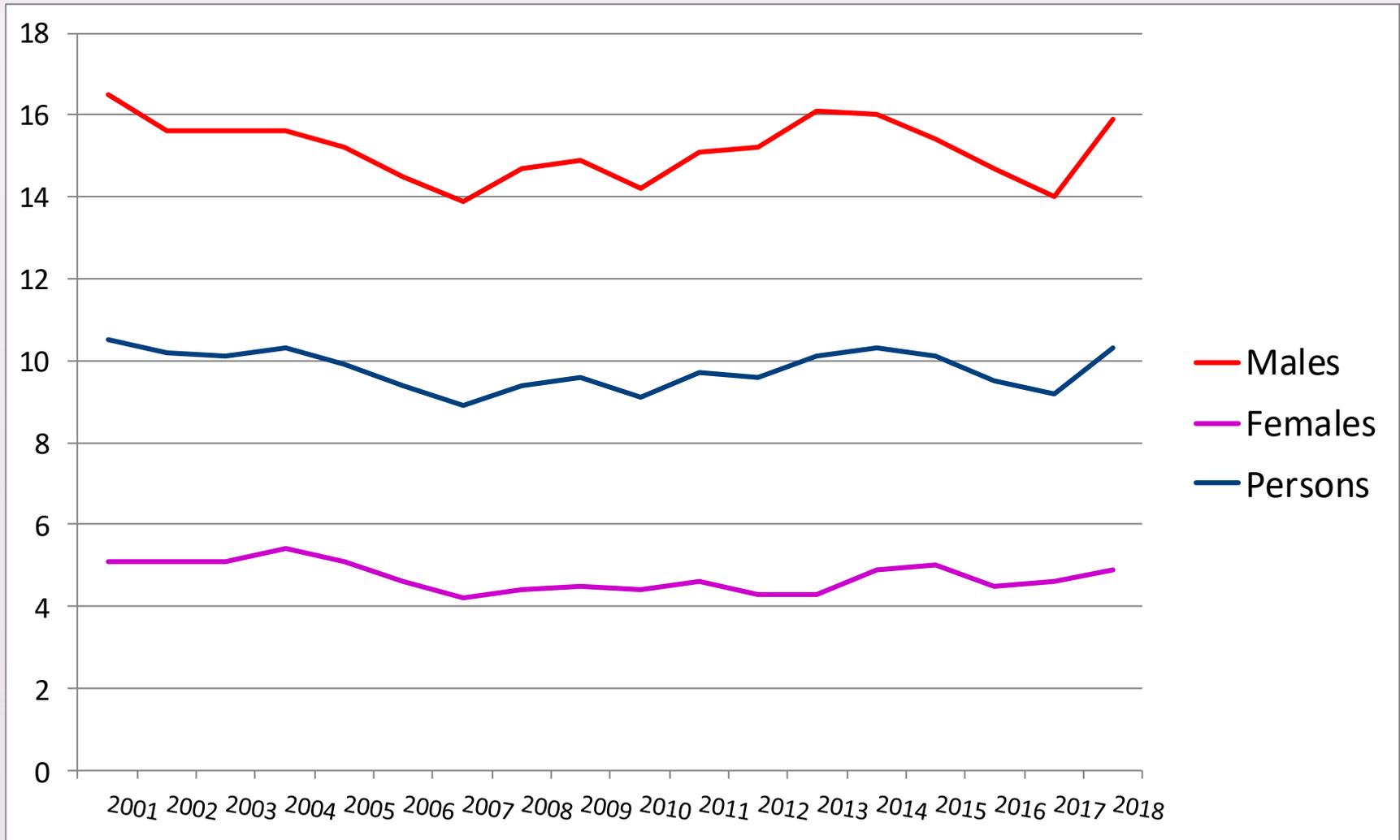


Self-harm and Suicide Prevention: updates on the latest findings

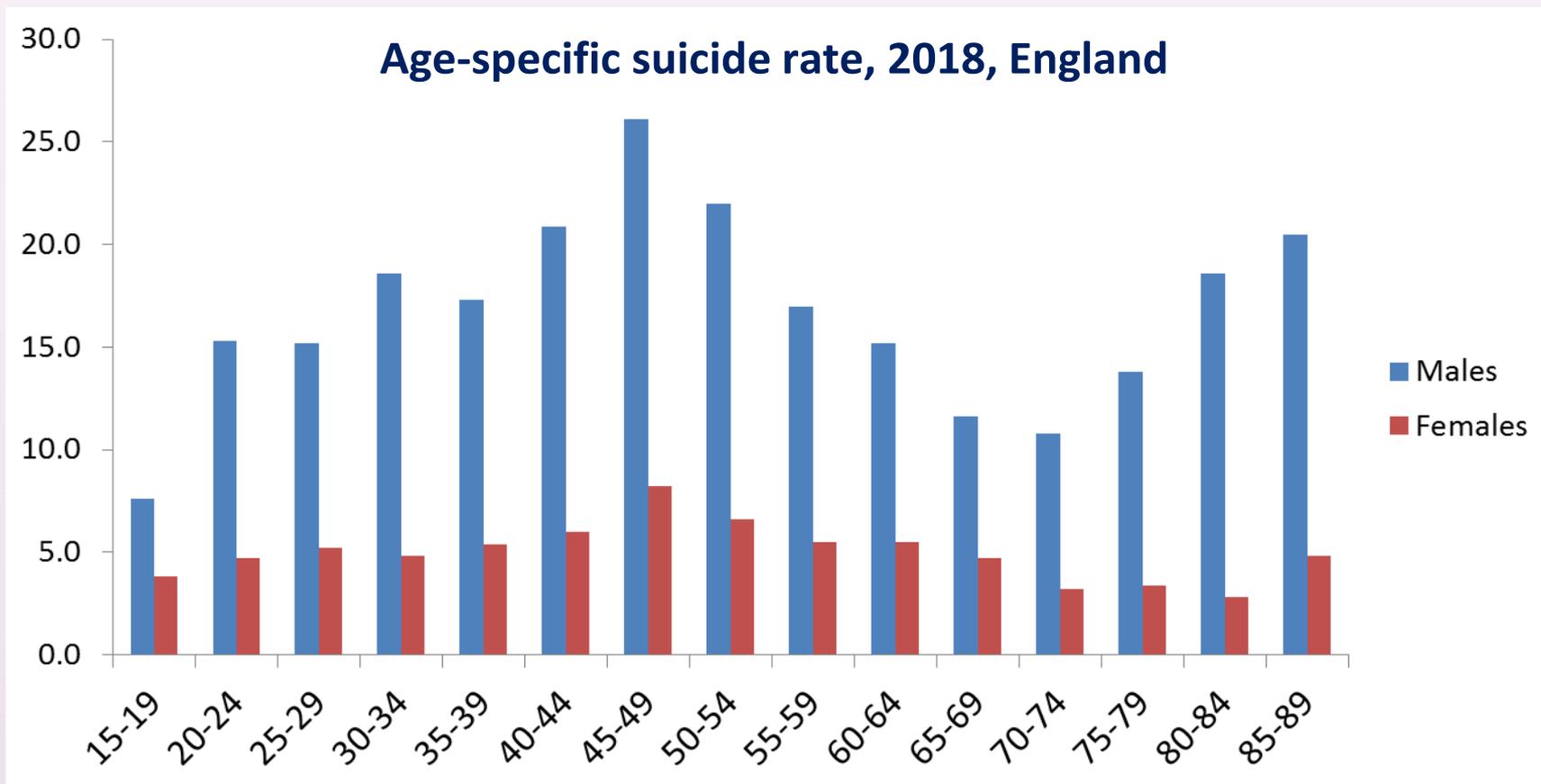
NCISH

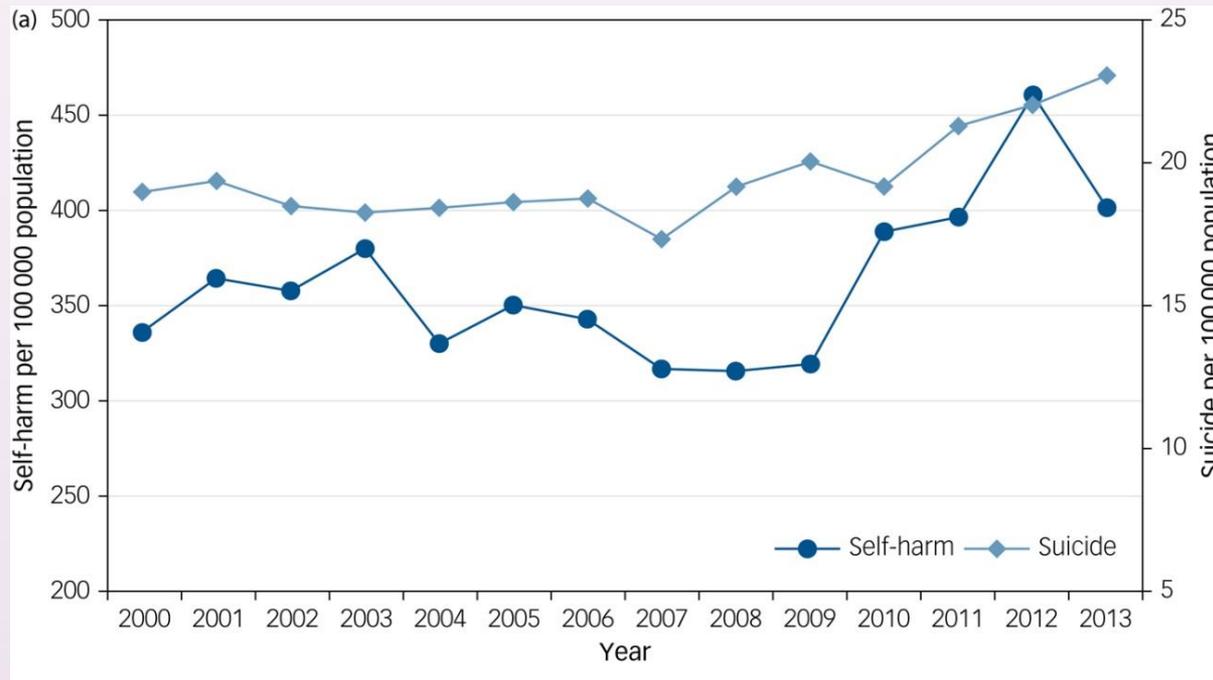
Suicide Prevention Learning Event 17th September 2019

Professor Louis Appleby



Gender differences





- Rise in self-harm linked to rise in suicide
- Self-harm rise linked to economic factors and alcohol

Journal of Affective Disorders 257 (2019) 173–179

Contents lists available at ScienceDirect



ELSEVIER

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad



Research paper

Access to means of lethal overdose among psychiatric patients with comorbid physical health problems: Analysis of national suicide case series data from the United Kingdom



Alexandra Pitman (Formal analysisWriting - original draft)^{a,b,c}, Su-Gwan Tham (Formal analysisData curation)^c, Isabelle M. Hunt (Formal analysisData curation)^c, Roger T. Webb^{c,d,e}, Louis Appleby^c, Nav Kapur^{c,d,e,f}

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^e NIHR Greater Manchester Patient Safety Translational Research Centre, UK

^f Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

ARTICLE INFO

Key words:
Suicide
Means restriction
Overdose
Physical health co-morbidities
Prescribing

ABSTRACT

Background: Many physical health problems are associated with elevated suicide risk whilst also providing access to means of overdose. We aimed to investigate whether psychiatric patients with physical co-morbidities who die by suicide were more likely than those without co-morbidities to self-poison with non-psychotropic medications.

Methods: We analysed data on 14,648 psychiatric patients who died by suicide in England & Wales during 2004–2015, as recorded by the National Confidential Inquiry into Suicide and Safety in Mental Health. Using logistic regression models adjusted for age, gender, ethnicity, and primary drug dependence/misuse we compared patients diagnosed with physical co-morbidities versus those without to assess whether a greater proportion of the former had died by overdose, and medication prescribed to treat such disorders (e.g. opioids, insulin).

Results: 24% (n = 3525) were recorded as having physical co-morbidity. A greater proportion of these individuals died by self-poisoning than those without physical co-morbidity (37% vs. 20%, p < .001; adjusted OR 2.47; 95% CI 2.26–2.70), and they were more likely to have used medications for a physical health disorder in overdose (50% vs. 34%; adjusted OR 2.10; 95% CI 1.80–2.46), particularly opioids (30% vs. 22%; p < .001), paracetamol/opioid compounds (11% vs. 7%, p < .001) and insulin (4% vs. 1%, p < .001).

Limitations: Use of survey data may have resulted in under-reporting of physical health problems and/or overdose medications.

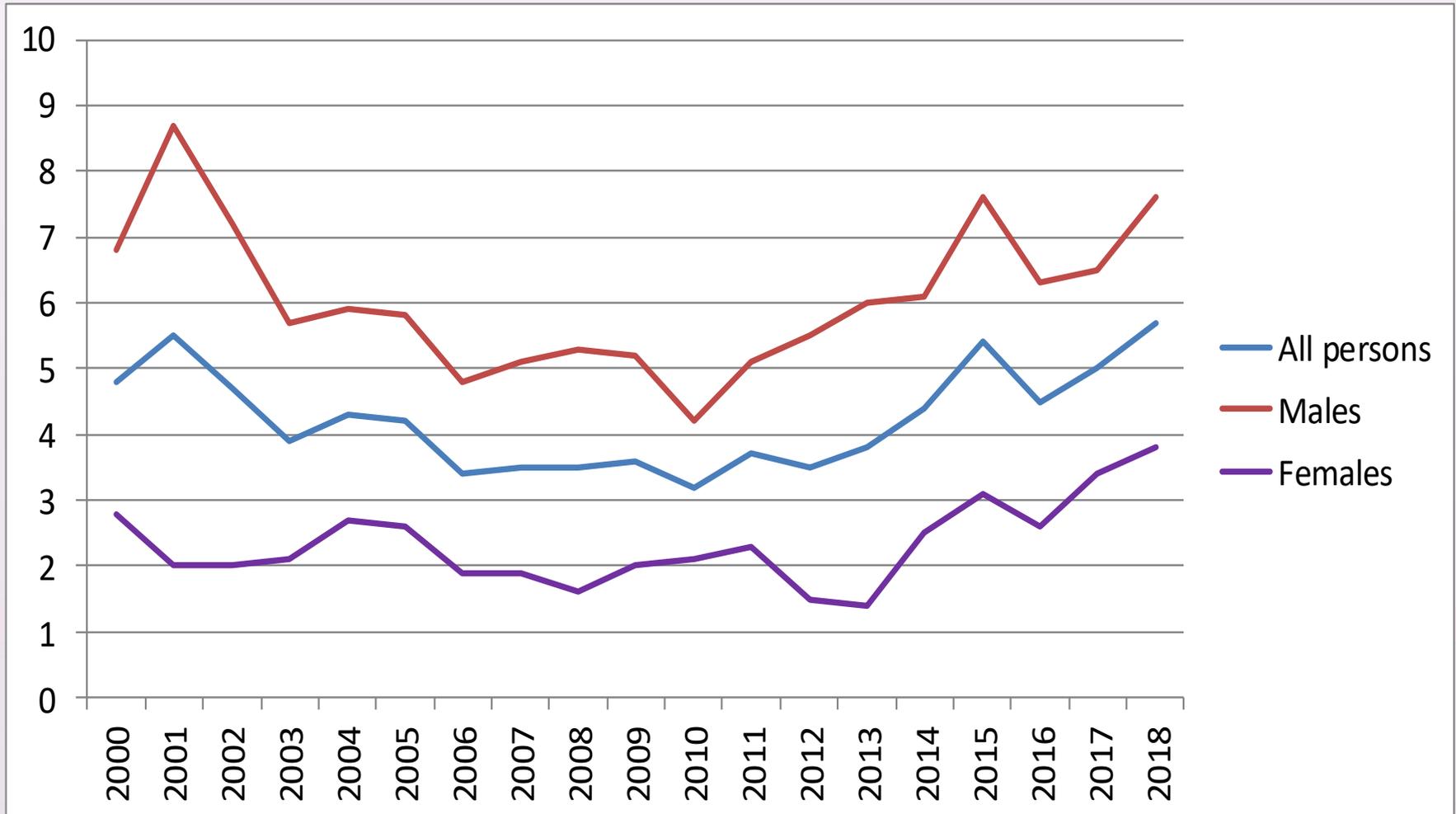
Conclusions: Overdose, rather than hanging, is the leading cause of suicide among psychiatric patients with physical co-morbidities, particularly using non-psychotropic medications. There is potential for means restriction in preventing suicide among these patients.

1/4 patients who die by suicide have a physical comorbidity

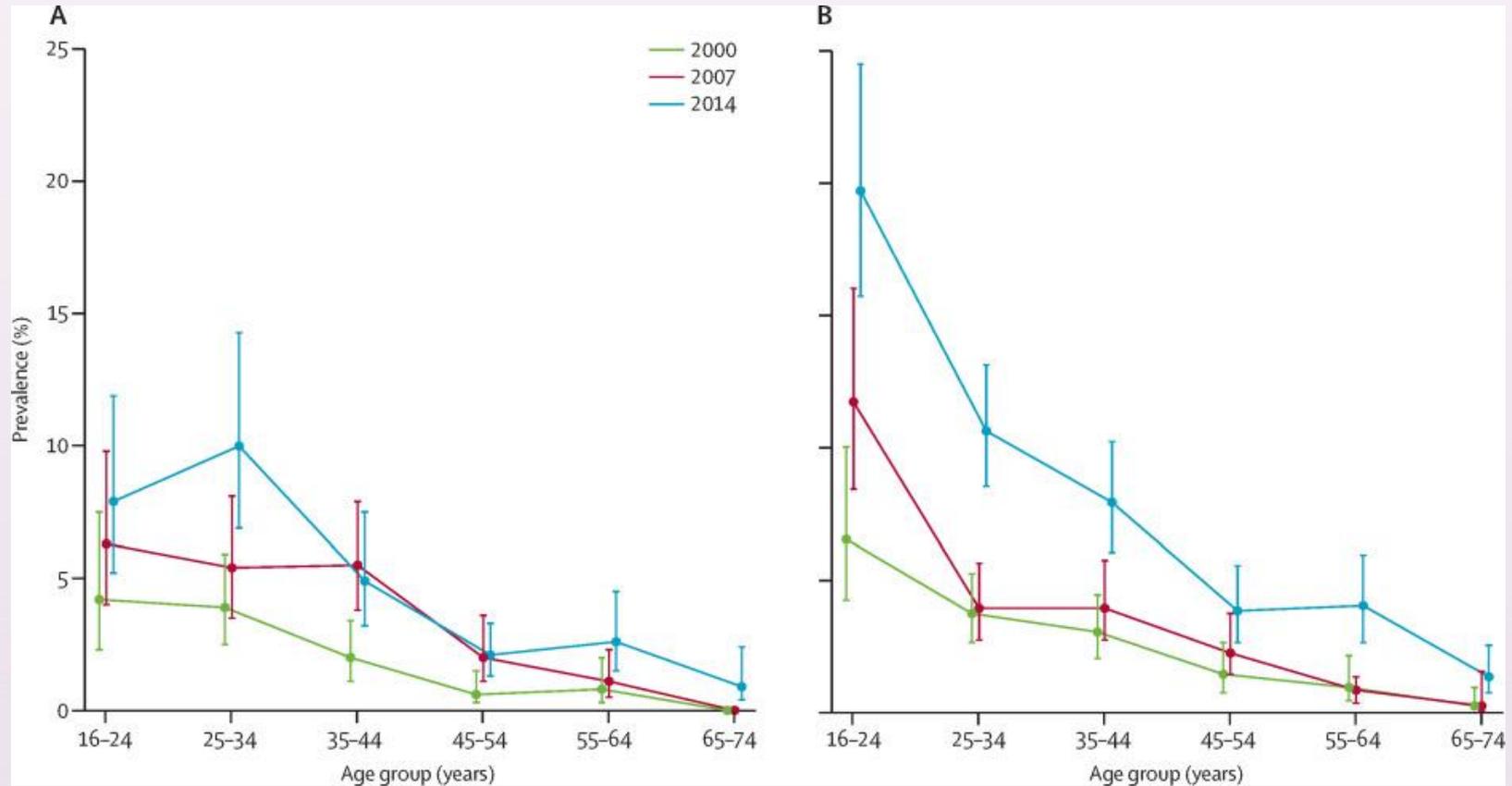
Overdose is the leading cause of suicide

Opioids are the commonest substances used

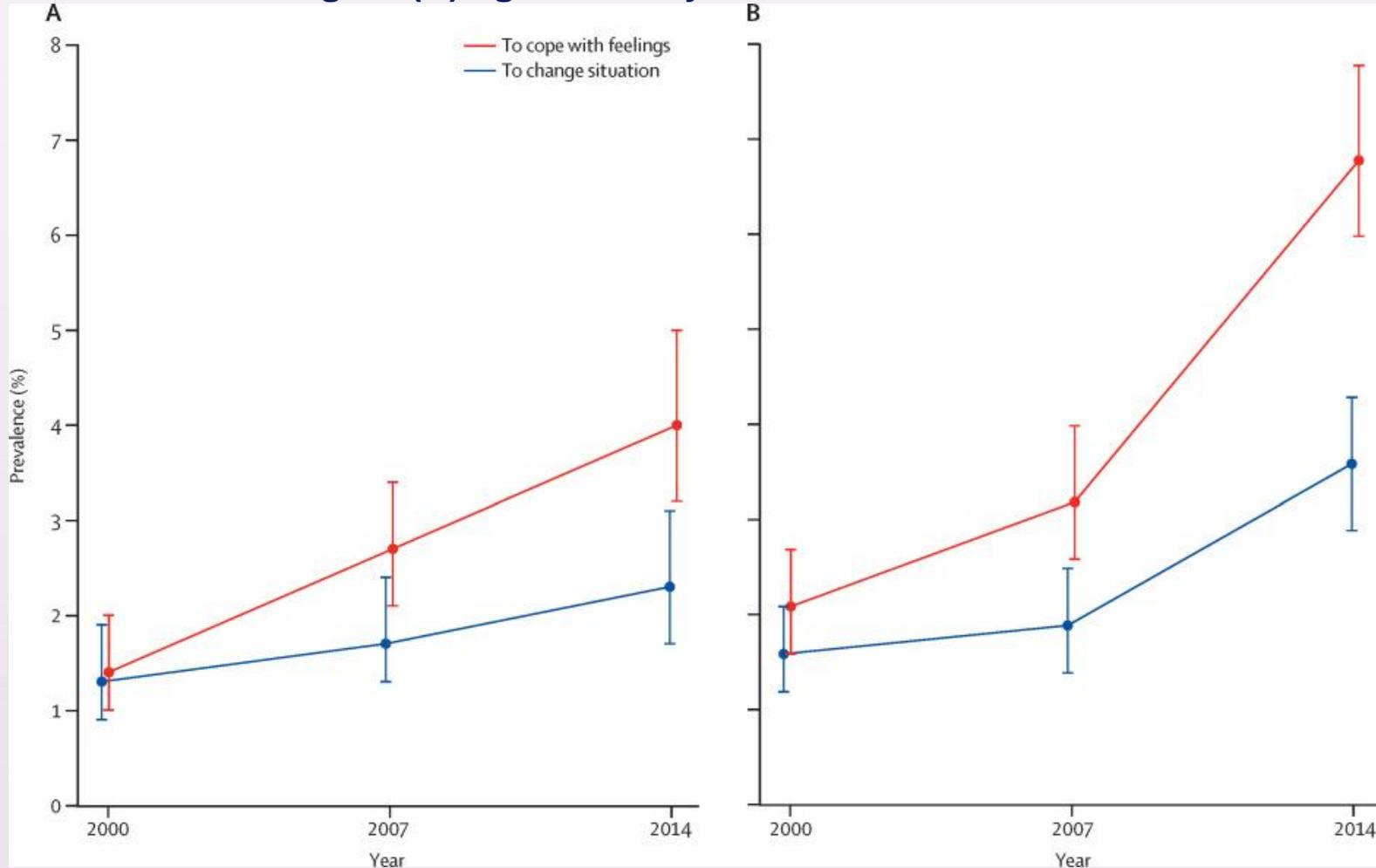
Suicide rates in 15-19 year olds, 2000-2018



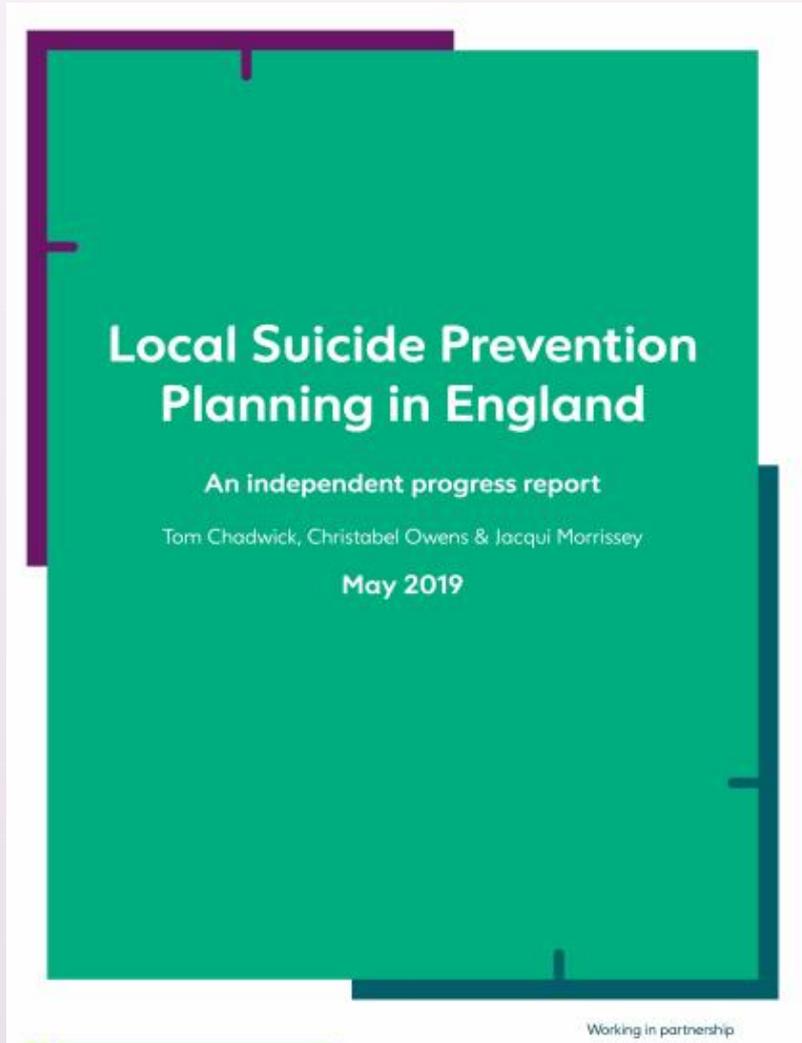
Prevalence of non-suicidal self-harm in men and boys (A) and women and girls (B), by age group



Reasons for non-suicidal self-harm among men and boys (A) and women and girls (B) aged 16–74 years



Local Suicide Prevention Planning in England



99% of LAs have established/developing a suicide prevention action plan

Plans covering 3 priorities:

97% reducing risk in **men**

92% prevention and response to **self-harm**

83% improving **acute mental health care**

Other plans:

97% bereavement support

92% improving mental health of children and young people



www.manchester.ac.uk/ncish



@NCISH_UK



Lunch

12:45 – 13:10



Introduction to the afternoon session

Real-time Surveillance

LANCASHIRE AND SOUTH
CUMBRIA STP



Healthier Lancashire & South Cumbria

Suicide Prevention - Real Time Surveillance

Neil Smith – Multi Agency Strategic Lead

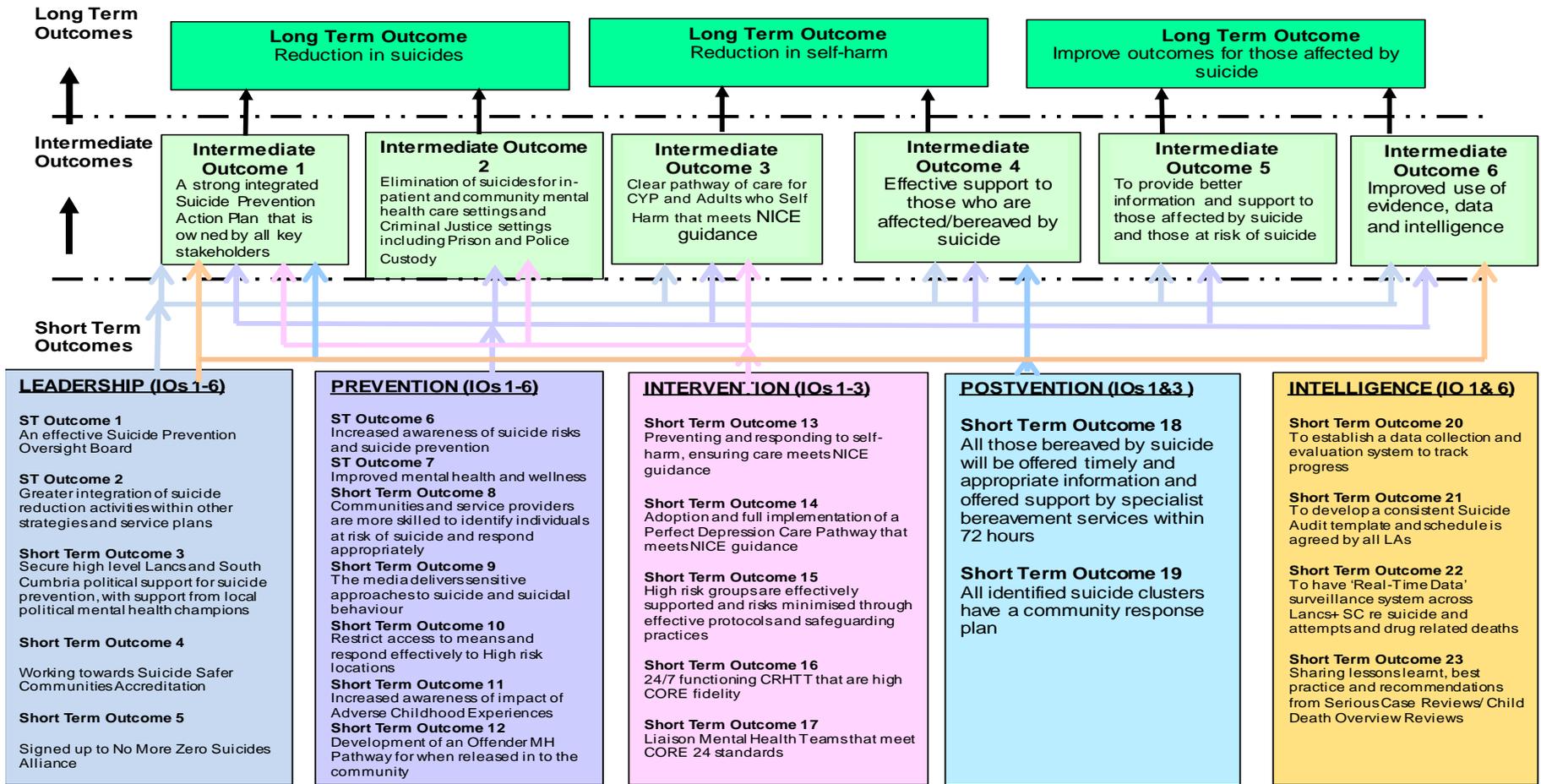
Pierce Rodway – Research and Data Analyst.

- Population of 1.7 million
- 4 Upper Tier LA's
- 14 District Councils
- 2 Police Constabulary's
- 9 HM Coroners
- 2 MH Trusts
- 8 CCG's
- MH in top 3 Strategic ICS Priorities

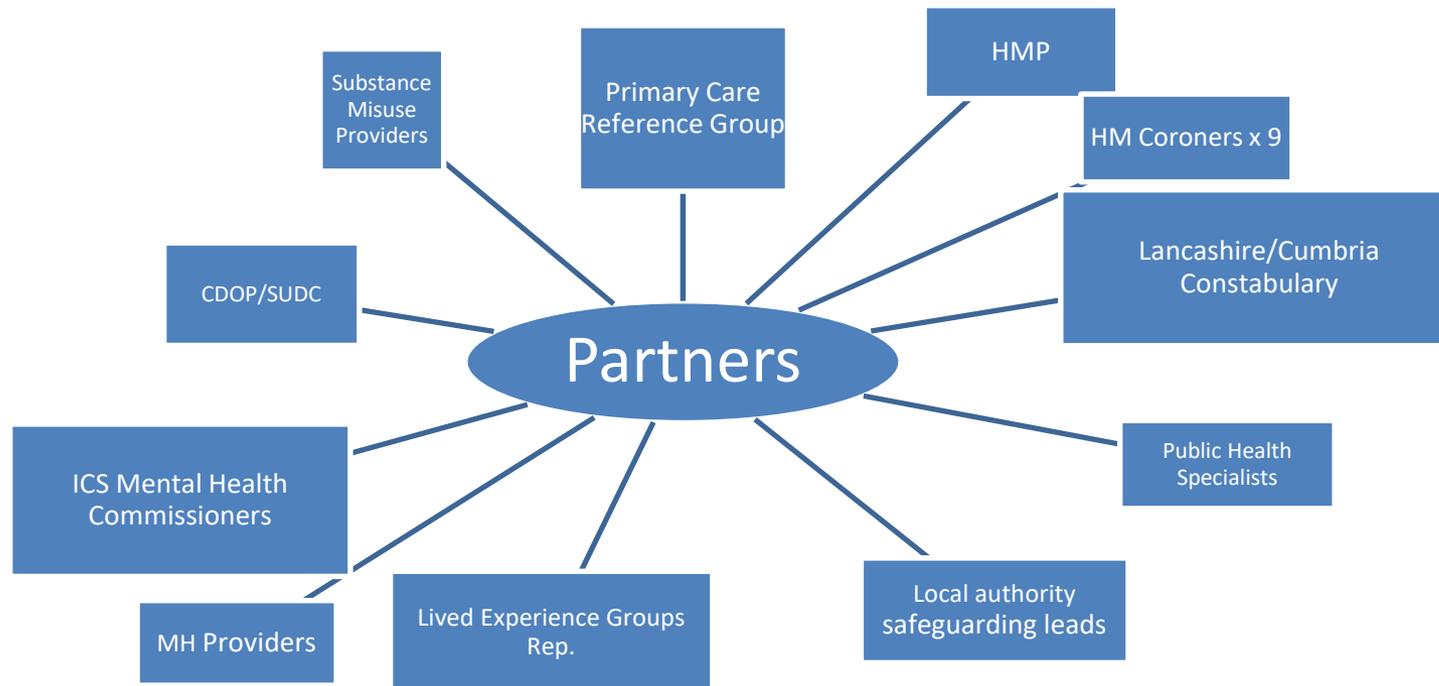
- ICS Leadership at Senior Level
- ICS Suicide Prevention Oversight Group Established with all key partners
- Logic Model ICS Plan developed and linking the 4 existing Local Authority Public Health SP Plans.
- Development of strong relationships with Police and Coroners
- Dedicated Research and data analyst capability.
- Data Sharing Protocol developed and agreed across system.
- Multi Agency Real Time Task Group established

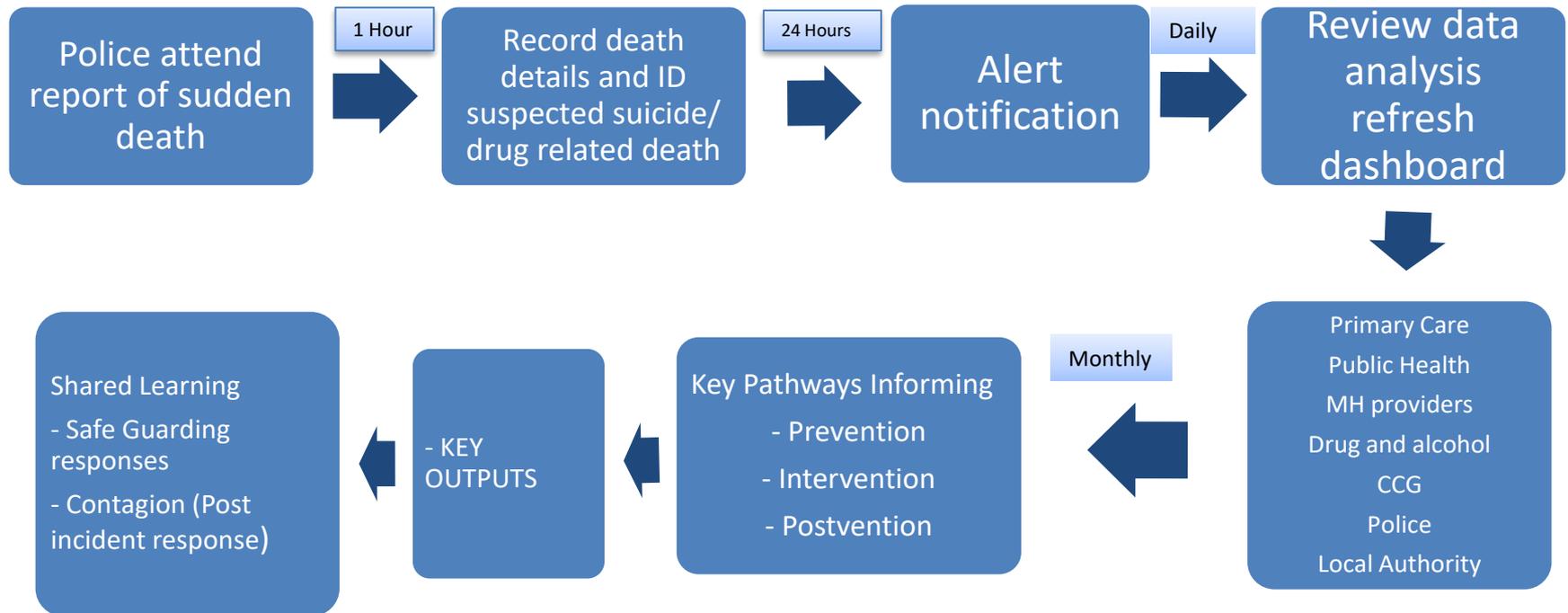
Lancashire and South Cumbria STP
Suicide Prevention Logic Model

Vision Lancashire and South Cumbria residents are emotionally resilient and have positive mental health



- Real Time Surveillance Multi Agency Working Group reporting to Oversight Group.

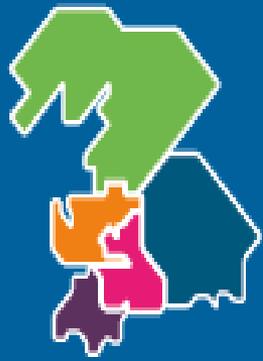




1. Suicide Prevention is everyone's Business.
2. We agree to share information and data across organisations to increase learning and new action opportunities.
3. We will be intelligence led in all our responses to real time information.
4. We will work together and collaboratively to increase our capacity to prevent self harm and suicide.
5. We share the 'prevention' challenge and accept mutual accountability to reduce suicide and self harm.
6. Rapid delivery of local responses to local problems supported by timely research and analysis.

Type	Suspected Suicide – Hanging
Incident Ref	LC-20190903
Date	01/01/58
Location of death.	21, Smith Street, Hoghton, PRESTON PR5 9JJ
Name	Neil JONES
Date of Birth	23/06/58
Age	61
Gender	MALE
Home Address	As above
Occupation	College Lecturer
GP Details	Dr Burnie, St James Medical Centre, Burnley Road, Rawtenstall
MH Issues/known to MH Services	None stated
Bereavement Offered?	No
Details	<p>Sudden death by Hanging</p> <p>Police will provide copy of the reporting officers report which will give details and circumstances of the incident and discovery of the deceased.</p>

- Benefits of a Multi Agency Real Time Working Group
 - Early engagement and partnership agreement with HM Coroner and Police.
 - IG – Info Sharing Agreement developed and signed off early.
 - Relationships with existing SP Groups within LA areas.
 - Engagement with ‘Lived Experience’ to shape outputs.
 - Dedicated research analytical capacity.
 - Post incident response protocols –
- child deaths links to CDOP
 - Mapping and Linking to existing Serious Incident Reporting and Safeguarding Groups (Joining the conversations)
 - New Business so seen as additionality.



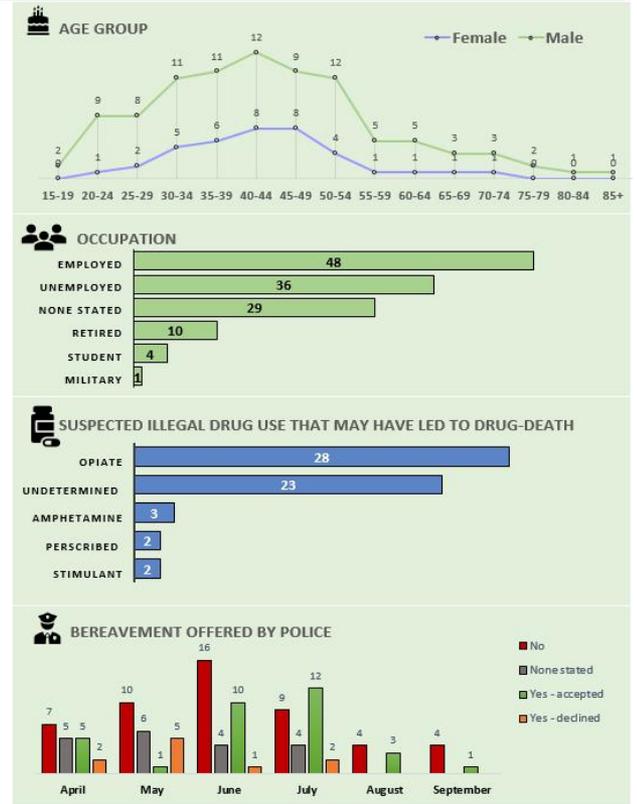
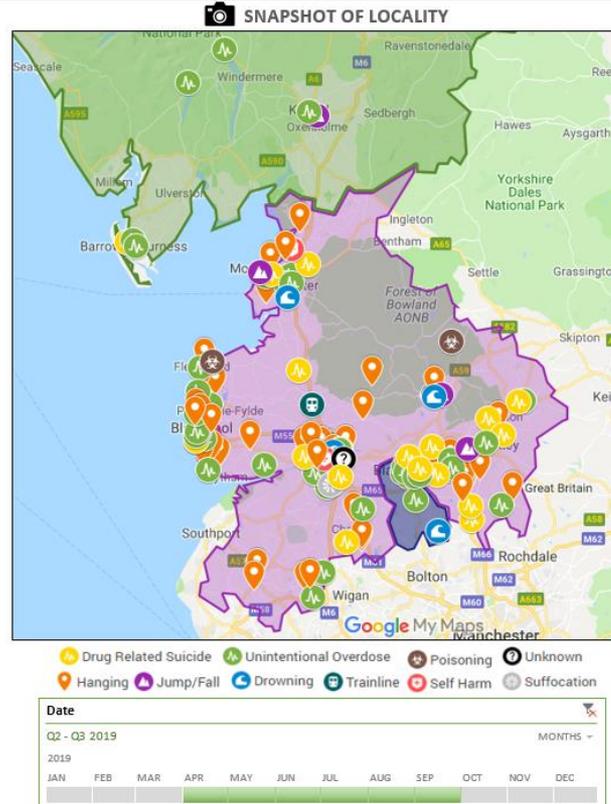
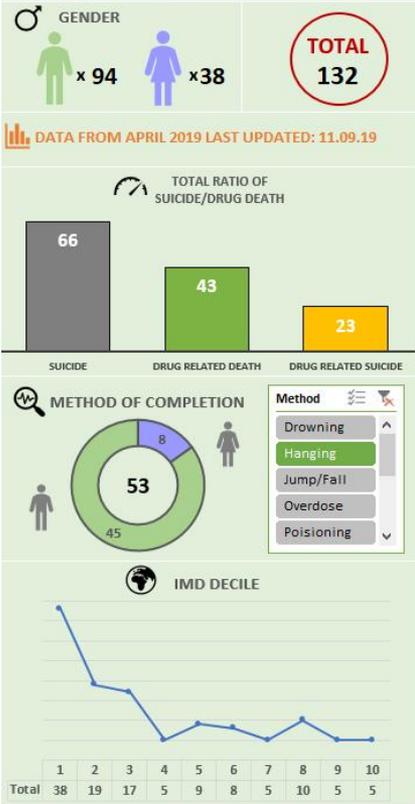
Healthier Lancashire & South Cumbria

WHATS IS REAL TIME TELLING US?

PIERCE RODWAY

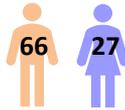


- As of 11.09.19, there have been 132 deaths in the Lancashire and South Cumbria area since April
- Drug death accounts for 66 deaths in total with 43 if those suspected to being unintentional overdose and 23 deemed to be suicide completion.
- Hanging is the most common method of completion by 45 males and 8 females – equating to a total of 53
- June was the highest month on record so far for drug related deaths (suicide & unintentional overdose) but July had the most suicides by non- narcotic method
- 75% of deaths occurred in their place of residence in August. There has only been 23 out of 132 deaths since April that did not take place at home. 4 of these are yet to be determined
- As of yet, here is no solid evidence to suggest that unemployment plays a factor in the overall statistics. Those in employment top the chart with completions. It is worth noting that those who work in labouring posts seems to be a trend
- For both male and female, the age bracket of 40-44 is the highest, however, age brackets for males who are 30-34, 35-39 and 50-54 is climbing and close to topping the most common age
- The most deprived areas of a IMD Decile rating of 1 experience the most completions (Blackpool being the highest, followed by Blackburn & Preston) however, there is a spike in the IMD rating of 8 in pockets around the Lancashire and South Cumbria area
- Opiates is the most common drug used when encountering drug death, but a further deep-dive is needed, as more 'prescription' drugs such as Pregabalin, Diazepam and Mirtazapine has shown up frequently in the data



This is the 'Overview' Dashboard, which is an element of the RTS Toolkit which is sent to partners and key stakeholders as a general overview for all updates regarding suicide and drug deaths that occur in the Lancashire and South Cumbria area. This Dashboard is dynamic where results will update to whatever month you wish to view, or what method.

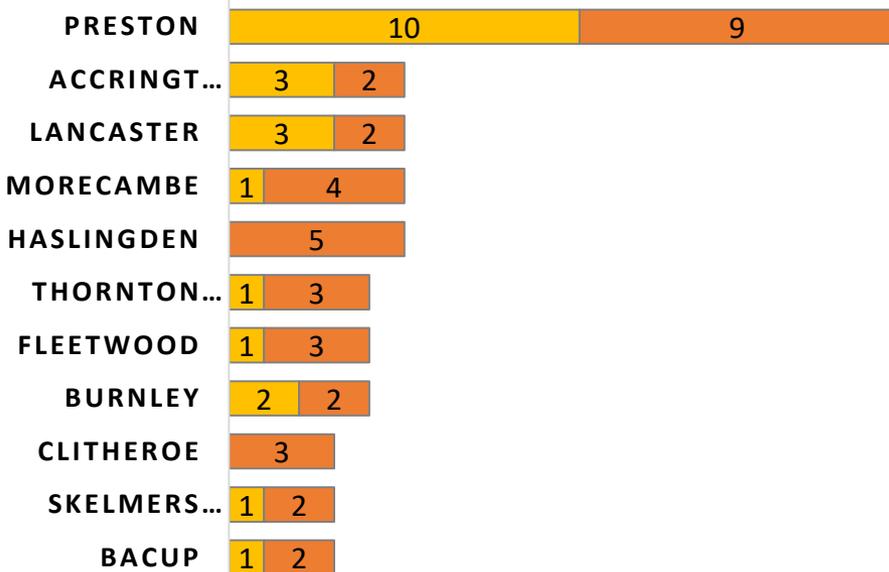
TOTAL: **93**



- Lancashire LA has the highest number of deaths, but does cover a massive patch in comparison to BwD, Blackpool and Cumbria. Preston heavily outweighs other areas by a considerable margin. There is a fairly even split on common method of narcotics and hanging, however, there are a notable amount of drug related suicides
- It is worth noting that there are little 'pockets' of clusters in the Lancashire patch. For example, West Lancashire deaths in Ormskirk and Skelmersdale shows a number of hangings that have taken place (5 deaths by hanging to 1 drug death)
- The picture on the right displays the most prevalent area - Preston

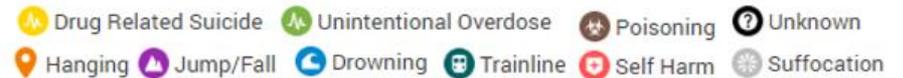
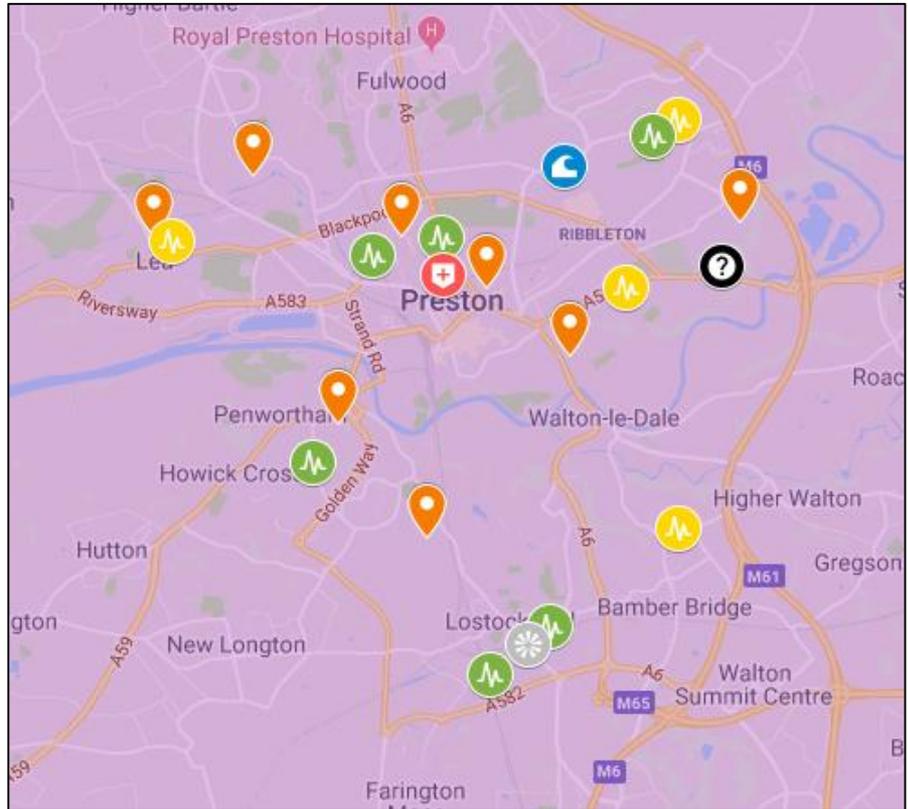


10 HIGHEST AREAS OF COMPLETION IN LCC PATCH



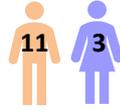
■ Lancashire County Council - Drug related

■ Lancashire County Council - Suicide

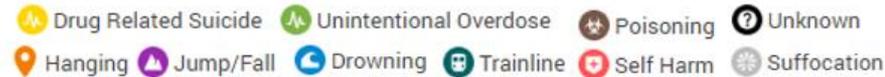
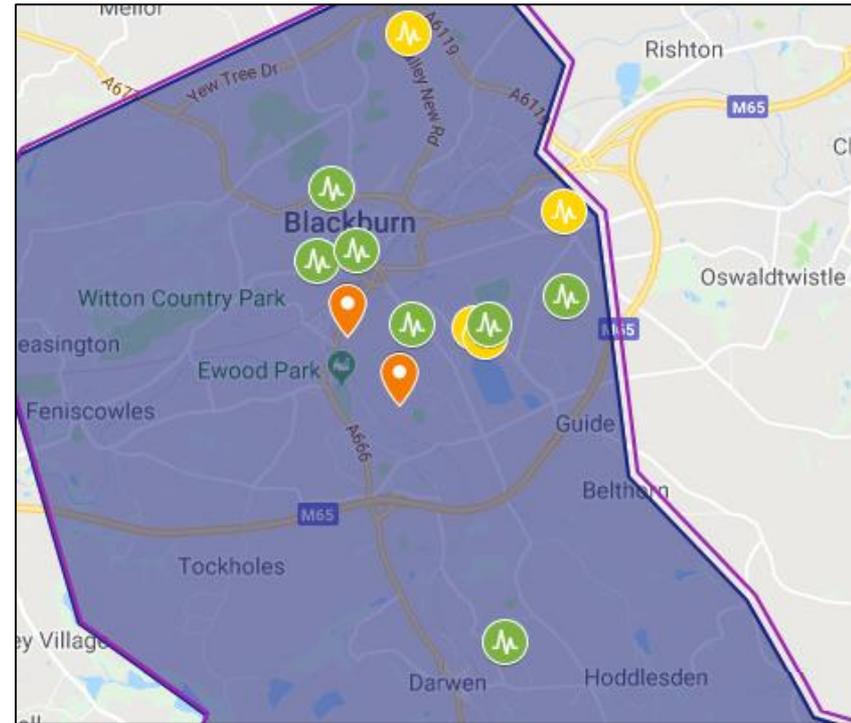




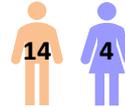
TOTAL: **14**



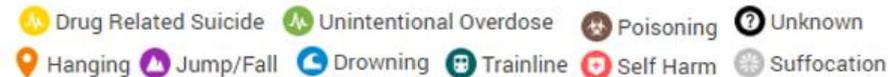
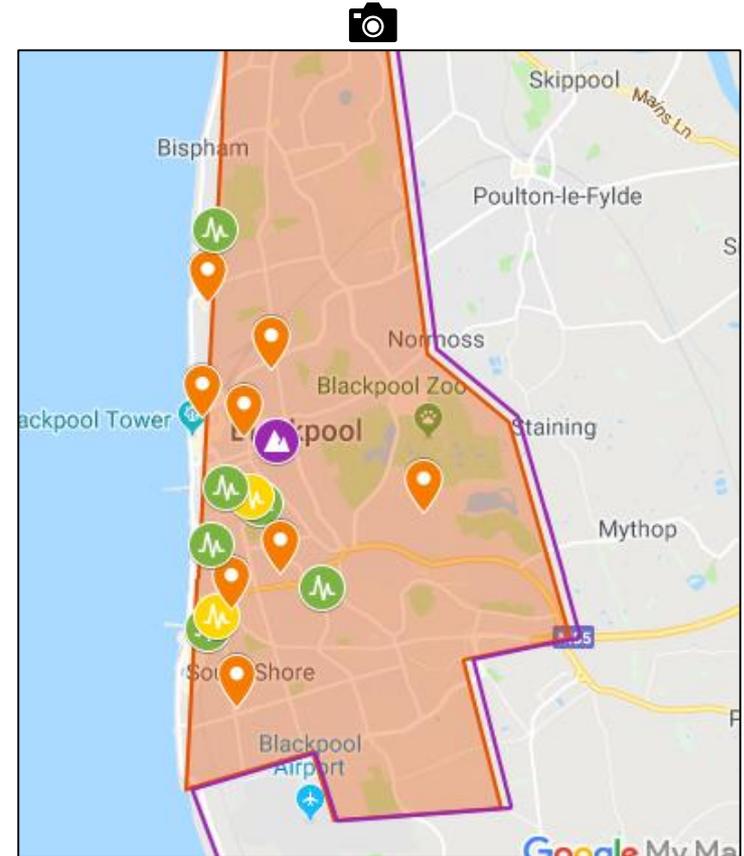
- BwD has a much smaller margin in comparison to LCC (as it is a much smaller patch) but has a particular cluster showing on the map with 11 deaths relating to drugs with the others 2 cases of hanging and one death by drowning (not shown on picture)
- The amount of drug related deaths is substantial in comparison to other areas with drug related suicide accounting for 4/11 deaths
- As the RTS is suspected only, the data cannot name drug which may have called death, but medical history in all of these deaths (regularly) include drugs such as: Methadone, Diazepam, Mirtazapine, Gabapentin & Pregabalin
- The most common age bracket has no obvious signs as of yet
- BwD data shows that 8 of the 14 were unemployed, which is an outlier in comparison to other areas



TOTAL: 18



- Blackpool has the highest level of deprivation in the RTS data
- Blackpool follows a similar pattern in the way Preston is, where there is just short of an even split with hanging and drug related death with unintentional overdose deemed to account for only a third of overall drug death
- Higher male to female in ratio of death, which is a similar pattern throughout
- One unfamiliar finding is the age group of those in the 20-24 range features quite prominently in the data
- Unemployment still tops the ratings, but not but the same margin as BwD
- The data also suggests that Blackpool area scores lowest in bereavement offered by Police



TOTAL: **7**



- The data for the RTS accounts for all of Cumbria, but these results are based on South Cumbria only. This is fairly new data
- There is a noticeable trend of drug related deaths in the South Cumbria area, with the remaining death being considered a 'fall'
- Barrow in Furness has a cluster forming (circled in red)
- Unfortunately, we do not yet have the data to show what drugs this may have been

Continuous work with RTS

- Deep-dive in areas such as those known to known to MH services will be added to Toolkit/Dashboard in due course
- On-going connections with other services to try and paint of picture of the process that may have led to death, this includes working with Medicine Safety for prescription rates, meeting up with CGL and Blackpool to gather intelligence on drugs and alcohol and the Police for any recent history of the deceased
- Thankfully, there has been a drop in the amount of suspected suicide and drug death since a considerable spike in June
- ONS figures that were released in September look like it will follow the same pattern as displayed on this Dashboard from April – Sept alone
- Continued efforts will be made to connect all the dots and make sense of the data in a way that affirmative action can be taken to drop suicide and drug-death rates

- DASH BOARD Development
- Trends and Risk identified earlier.
- Intelligence led responses based on 'Real Time' Data.
- Establish key learning events across wider system
- Increase analysis with other organisations, MH, Substance Misuse, Social Care, CJ Agencies, Primary Care.
- Close 'suspected' to Coroners outcomes.
- Self Assessment Tool Kit developement



Healthier
**Lancashire &
South Cumbria**

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Join in the conversation on Twitter
@HealthierLSC

Self-harm

MERSEY CARE NHS
FOUNDATION TRUST

HOPE Therapy Service: Rapid Access to Brief Psychotherapy for Self Harm via A&E Liaison

Emma Mullin | Mental Health
Practitioner
Dr Cecil Kullu | Consultant
Psychiatrist



Self Harm

Definition

- Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress NICE 2004
- NICE Guidelines and Quality standards , CG16, QS34

Prevalence

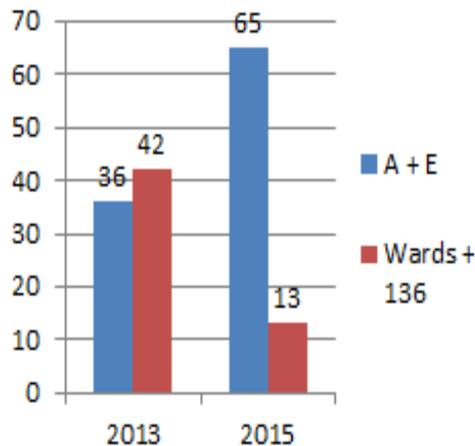
- 800,000 people die by suicide every year (WHO)
- General Hospital costs for Self harm (Keith Hawton et al)
 - Self injury: £753 (SD 2061)
 - Self poisoning:
£806(SD 1568)
 - Self injury and poisoning :
£987(SD 1823)

Prevalence

- Hospitals manage over 200,000 episodes of self-harm annually in England alone (National Institute for Health and Clinical Excellence, 2011)
- Studies demonstrate that self-harm can predict a suicide attempt over and above other well known correlates; BPD, Impulsivity, Depression (Klonsky, May & Glenn, 2013)
- The risk of suicide in the first year following the initial self-harm presentation is 49 times greater than the general population, especially in the first 6 months (Hawton et al., 2015)

Audit of self harm presentations to Acute Hospitals – 2013 & 2015

Place of review



Audit of Response Times and Outcomes for Attendances at Royal Liverpool University Hospital with Self-Harm

Mersey Care NHS Trust

Dr Amelia Gleghair CT3, Dr Tomos Williams CT3, Dr Stacey Alward F1, Supervised by Dr Cecil Kulu

AIMS AND HYPOTHESIS

- 1) To compare waiting times and standard of self harm assessments with previous audit
- 2) To examine demographic and clinical information of people presenting with self harm, especially repeat presenters.

We anticipate that the new Hospital Outpatient Psychotherapy Engagement Service, introduced before the reaudit, will have changed outcomes at 6/12 for patients presenting with self harm.

BACKGROUND

Self harm occurs in 5.4% of women and 4.5% of men, accounting for 0.07% of Accident and Emergency attendances. 20.7% of patients with self harm reattend within a year, and self harm increases suicide risk by 50-100. Therefore, in April 2015 Mersey Care NHS Trust introduced the Hospital Outpatient Psychotherapy Engagement (HOPE) Clinic, providing brief psychotherapy in the days and weeks following self harm.

METHODS

We examined the first 78 cases of self harm from 1/4/15 in order to match the number in a previous audit in 2013. The 2013 audit tool was expanded to include further demographic information (gender, age, postcode) and clinical data (assessment information, diagnosis, outcome). Data was gathered from electronic patient records and self harm assessments were compared with NICE recommendations for risk and psychosocial assessment. The results were compared with information from the 2013 audit.

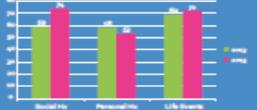
RESULTS

When compared to previous audit results, we found that patient waiting times had decreased. Demographics and method of self harm were largely unchanged. Risk assessments, social histories and drug and alcohol histories were improved but personal, psychiatric and self harm history taking was not as thorough as in 2013. Demographic information suggested that patients tended to come from areas of economic deprivation. Repeat presenters were more likely to have a diagnosis of Emotionally Unstable Personality Disorder and to be female. Disappointingly few patients had been referred to the HOPE clinic for people who deliberately self-harm, and fewer were admitted in 2015 than in 2013.

CONCLUSIONS

- 1) Assessment times improving; demographics similar between cohorts
- 2) Risk Ax Improved in 2015
- 3) Psychosocial assessment needs improving in some areas: refresher training to be provided to practitioners working with patients who self harm
- 4) The HOPE Clinic will need time to gain momentum - reaudit in 6/12
- 5) CMHTs to consider self harm input in deprived areas
- 6) Repeat presenters are a unique group - further investigation needed as well as increased resources

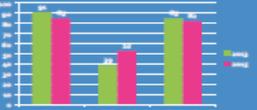
Psychosocial Assessment: 1



Psychosocial Assessment: 2



Psychosocial Assessment: 3



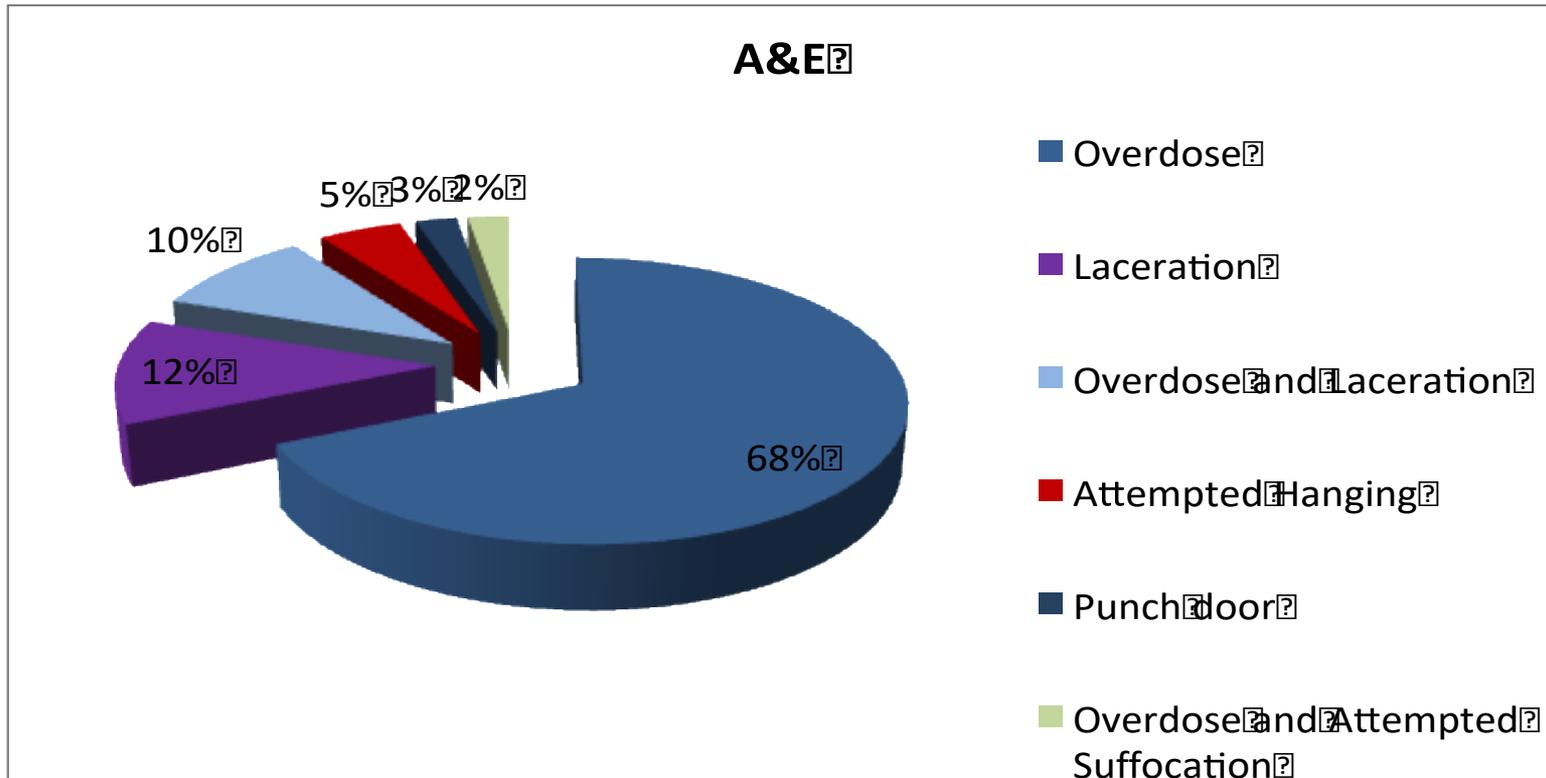
Risk Assessment



Patient Postcode: 2015



Type of Self-Harm



Audit: Self harm presentations at Royal Liverpool University Hospital, 2015.

Audit Outcomes

- Biopsychosocial assessment completed 95%
- 25% were new to services
- 55% were discharged back to primary care services
- Risk assessments had improved.

Audit of Response Times and Outcomes for Attendances at Royal Liverpool University Hospital with Self-Harm
 Mersey Care NHS Trust

Dr Amanda Clouhill CT2, Dr Tomos Williams CT3, Dr Stacey Allwood FT, Supervised by Dr Cecil Kufu

AIMS AND HYPOTHESIS

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- 5) CMHTs to consider self harm input in deprived areas.
- 6) Repeat presenters are a unique group - further investigation needed as well as increased resources

Psychosocial Assessment: 1

Category	2013	2015
Suicide risk	~85	~95
Personal risk	~85	~80
UK based	~95	~95

Psychosocial Assessment: 2

Category	2013	2015
Psychotic	~85	~85
Previous self-harm	~85	~75
Single episode	~85	~95

Psychosocial Assessment: 3

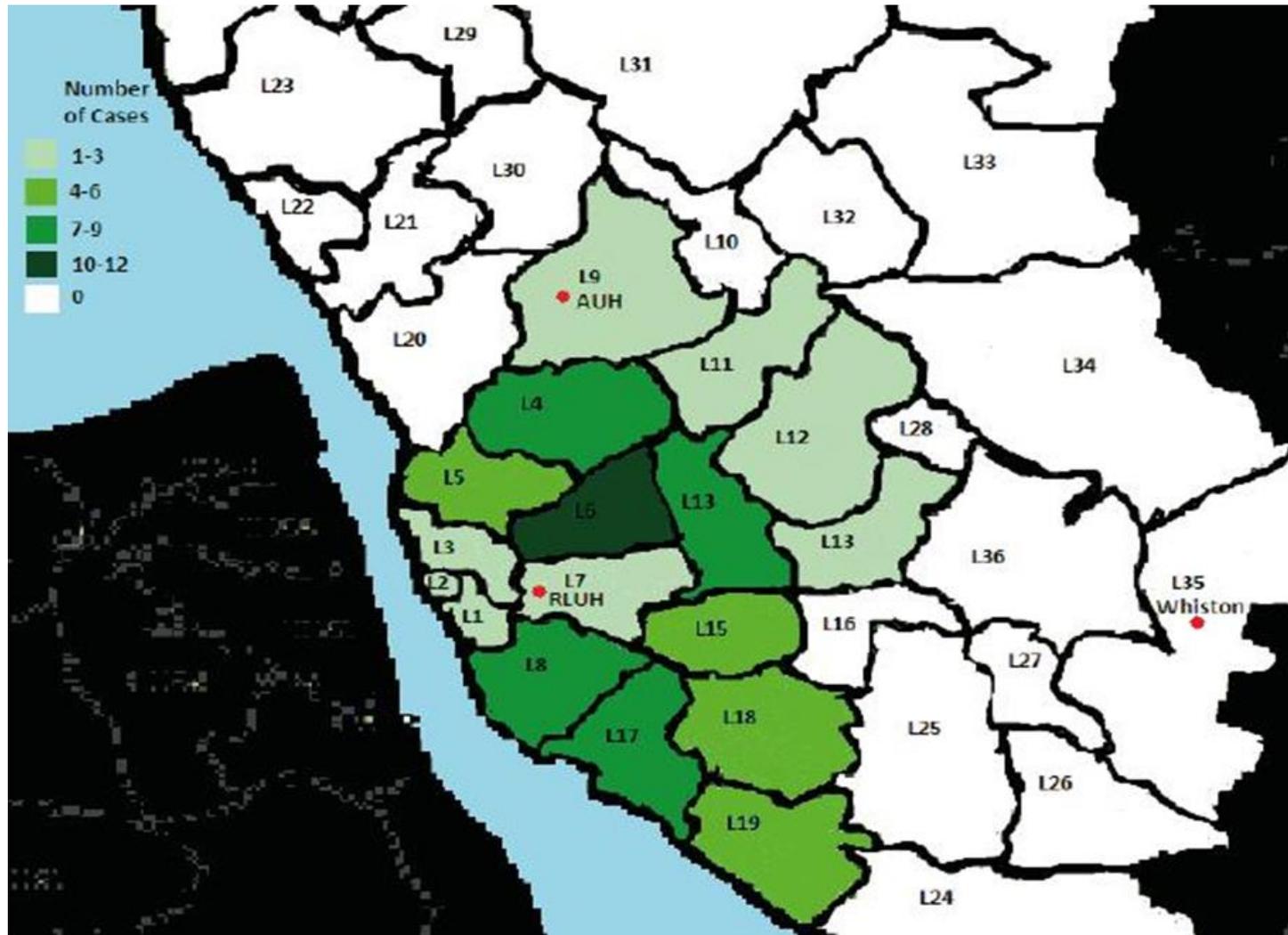
Category	2013	2015
HOPE	~85	~85
Psychology of act	~75	~85
Motivation for act	~85	~85

Risk Assessment

Category	2013	2015
Observer of act	~85	~95
Observer of Person	~75	~85
One of person	~75	~95

Patient Postcode: 2015

Audit outcomes



Therapy Model

- Psychodynamic Interpersonal Therapy+ Cognitive Analytic Therapy (adapted from Prof Else Guthrie)
- Circumstances that precipitate the self-harm episode are explored in detail and a rationale/formulation, linking feelings, problems and relationships is developed in a collaborative style

Who the service is designed for:

HOPE is eager to engage those who have self harmed for many years, or for the first time, but are not involved with mental health services.

Because of the nature of therapy, the team is not able to work with people who are alcohol or drug dependent. Residents of the Sefton area can be referred to our sister service based in Aintree Hospital.



Additional resources

You may not feel ready to start therapy right now, but want some support with self harm or the way you feel.

If you do want additional support, the following organisations (accessible on the internet) may prove helpful:

- Mind
- National Self Harm Network
- NHS Choices
- Harmless
- Samaritans



How to find us



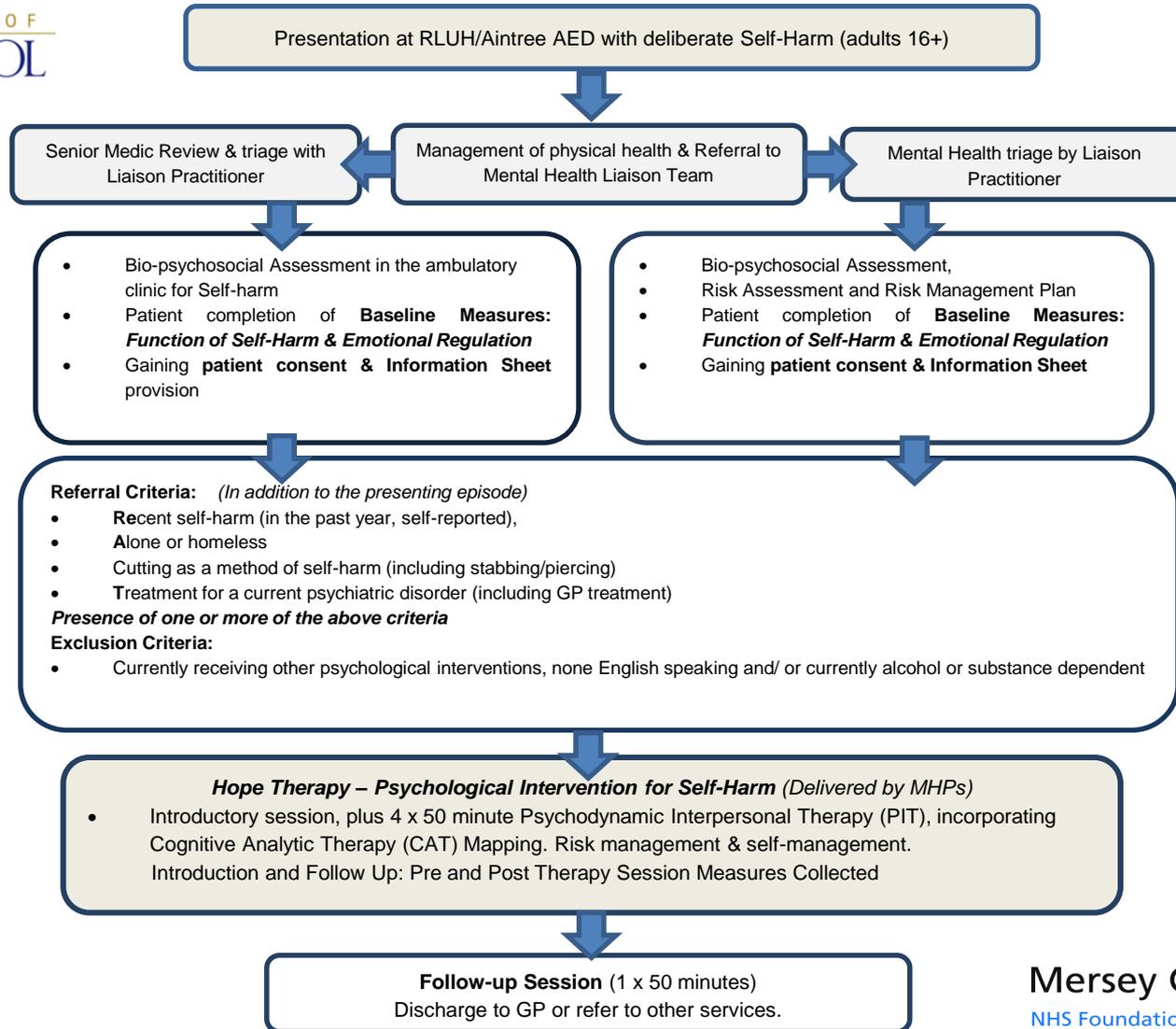
Contact us

HOPE Liverpool
Mental Health Liaison Team
Royal Liverpool University
Prescot Street
Liverpool
L7 8XP
Tel: 0151 706 3520

If you have any problems or anxieties regarding your appointments, please don't hesitate to contact a member of our team on the number above.



HOPE Therapy Liverpool: Care Pathway



Interim Summary



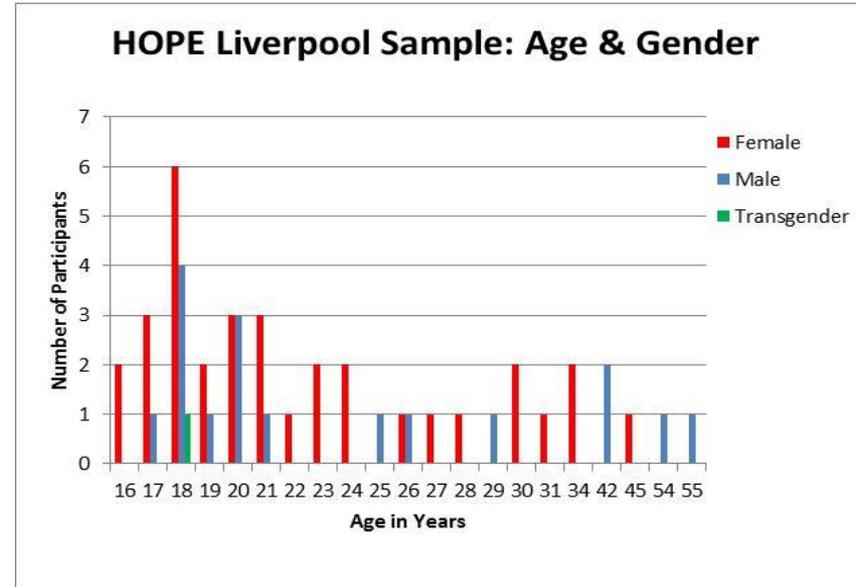
- Average Time to Treatment was approximately 2 weeks
- 50% reduction in ED attendance following Hope Therapy compared to Treatment as usual (Data from 2014)

HOPE Liverpool Evaluation

- Completed pre-therapy session:
 - **CORE 10 (Clinical Outcomes in Routine Evaluation)**
 - Widely adopted for the evaluation of psychological therapies
 - Comprising of depression (2), anxiety (2), functioning (3) general, social & close relationships, physical (1), trauma (1) & risk (1)
 - Scores Range from 0-4
 - **Additional Questions:** (Nock, Prinstein & Sterba, 2009)
 - Thoughts/Urge to self-harm (last 7 days)
 - Thoughts/Urge to attempt suicide (last 7 days)
 - Subjective Experience of emotions (last 7 days)
- Completed post-therapy session:
 - **Therapeutic Alliance** ((Miller et al., 2003)
 - Relationship
 - Goals
 - Approach
 - Overall

Sample Characteristics

Total Number of Participants (Engaging in at least 1 therapy session)	51
Age Range	16-55 years Mean Age 24.18 ± 9.23
Gender	Male = 17 (33.3%) Female = 33 (64.7%) Transgender = 1 (2%)



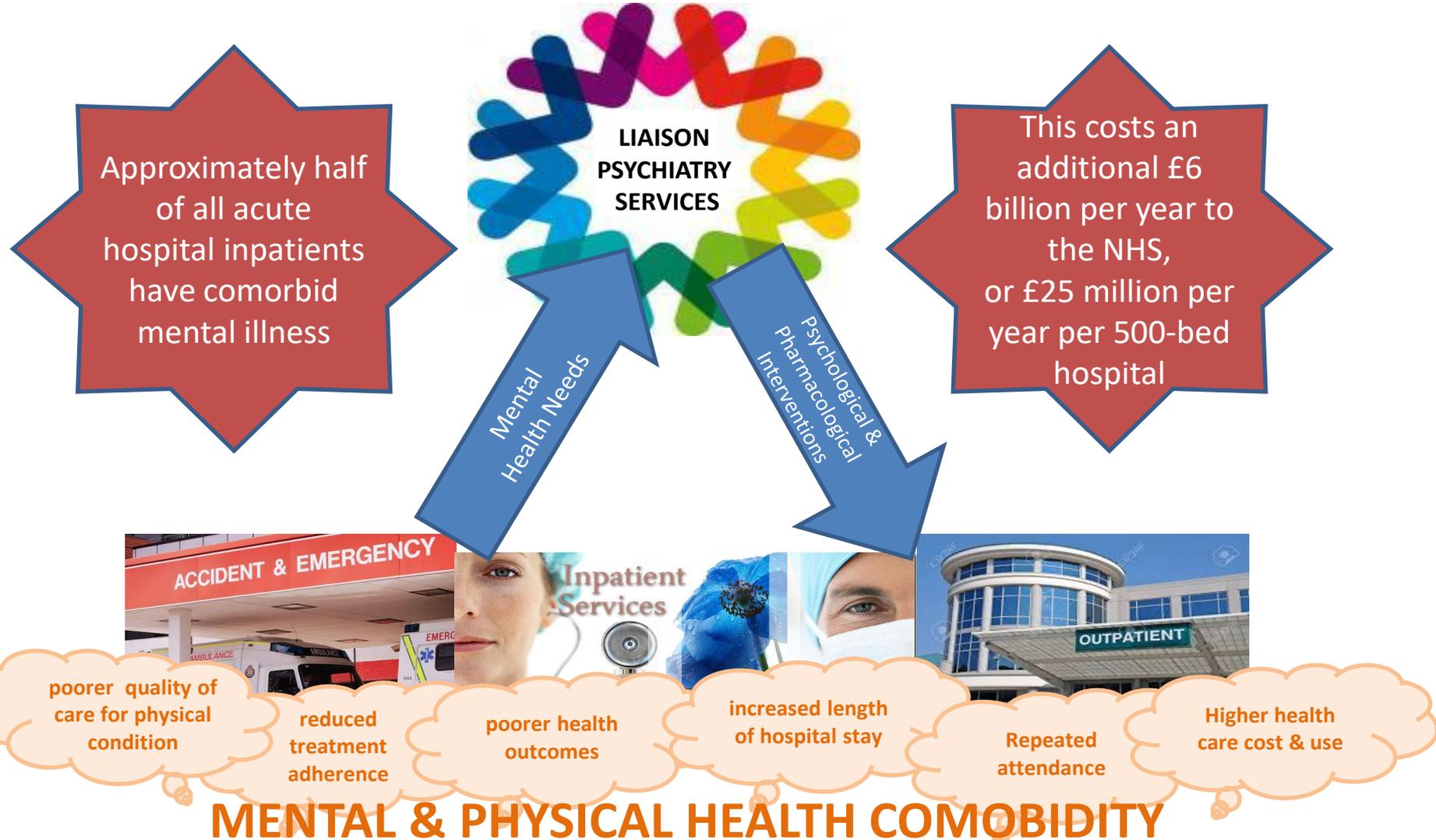
**Age Proportional
Representation**

**16-25 years
70.6%**

Summary

- Sample Size 51 participants
- 70.6% of referrals to HOPE during the pilot evaluation were in the 16-25 years age group, 64.7% female
- 47.1% of patients completed therapy
- Individual Clinical Change in Global Functioning: 13.88% significantly improved, 80.55% no clinical change and 5.55% clinically significant deterioration
- Individual Clinical Change in Risk: 11.11% significantly reported a reduction in suicide risk, 88.88% no clinical change and zero patients report deterioration in suicide risk following therapy
- Group Change post therapy: a statistically significant improvement in global functioning
- Therapeutic Alliance: scores begin high and the difference post therapy remains insignificantly changed

BACKGROUND



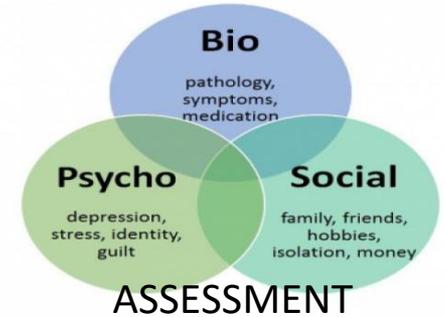
Approximately half of all acute hospital inpatients have comorbid mental illness

This costs an additional £6 billion per year to the NHS, or £25 million per year per 500-bed hospital



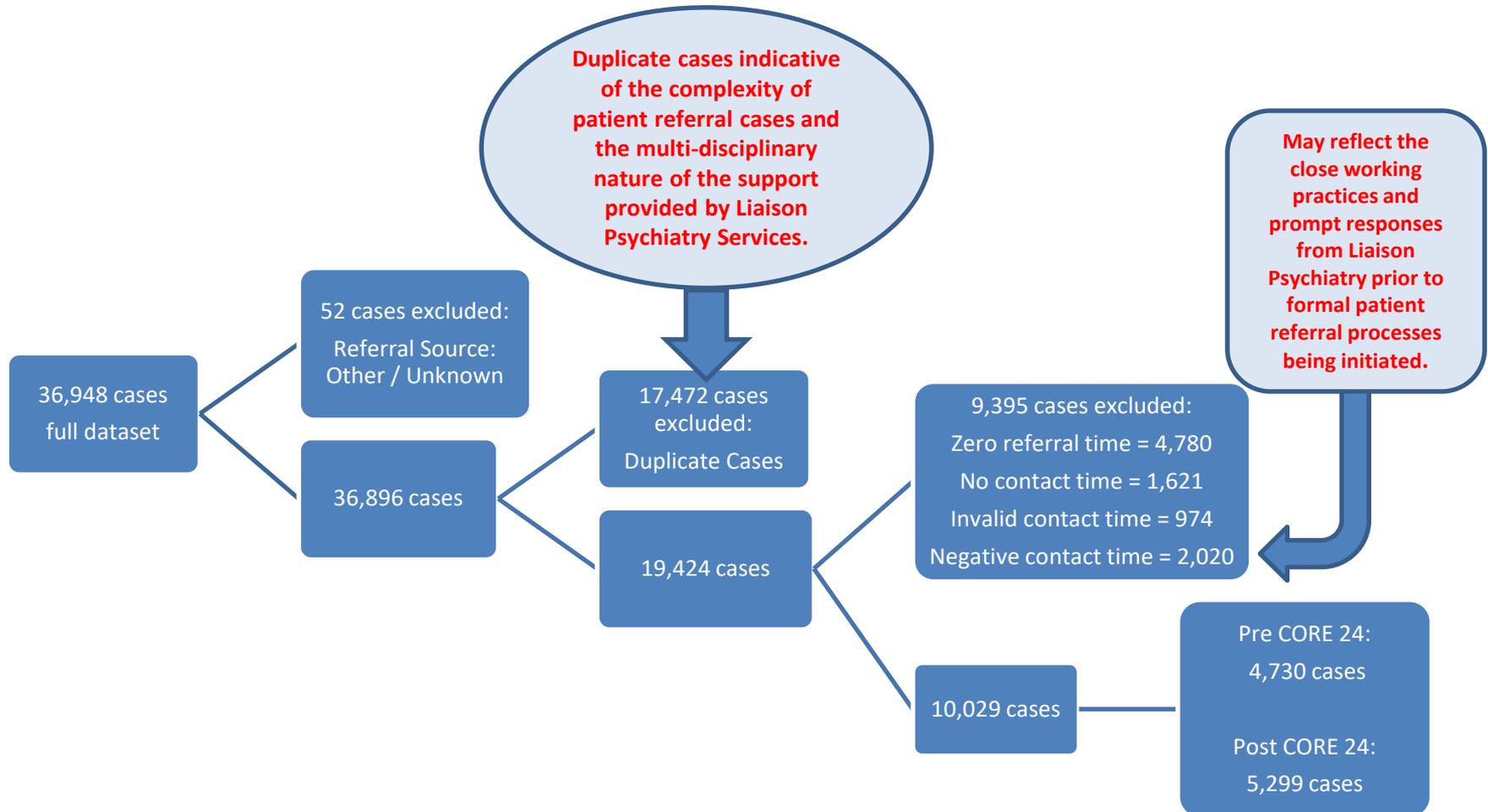
What does Core 24 Offer?

SPECIALIST CARE



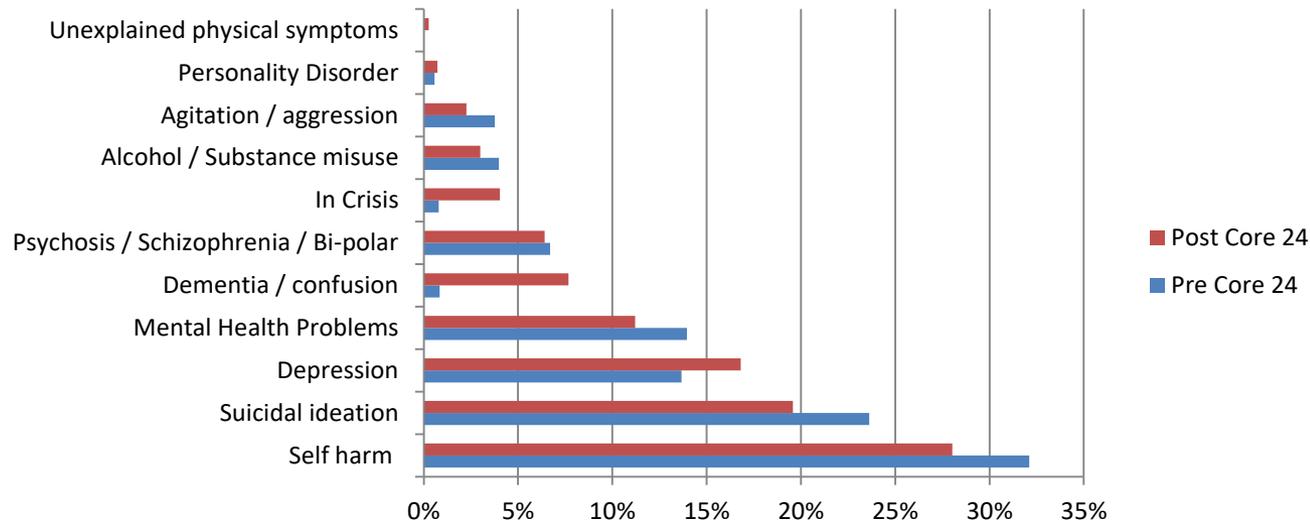
PSYCHOLOGICAL INTERVENTIONS

Patient Referral Case Flow



Patient Referral Reasons

**Known Patient Referral Reasons to Liaison Psychiatry Services
Pre and Post Core 24 Implementation**



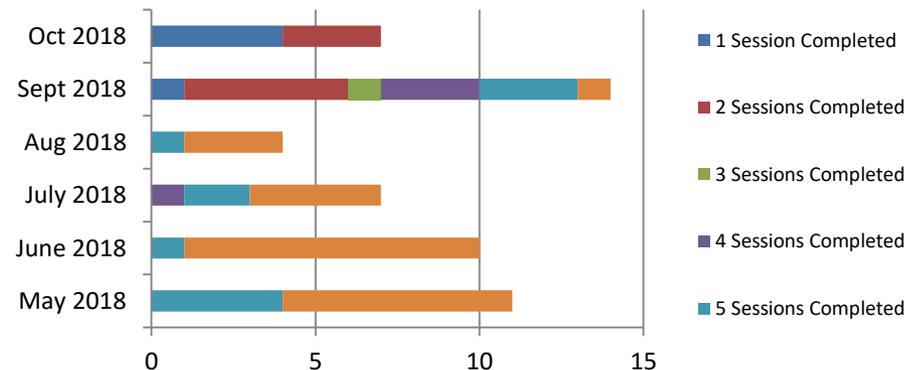
- **Self-harm** and **Suicidal ideation** remain the **most common reason** reasons for referral.
- Substantial increases in the number of referrals, pre to post Core 24, noted for: Depression; Dementia/Confusion; and Crisis referrals.

HOPE Therapy Service

- The HOPE Service provides a brief (5 sessions plus follow up) psychotherapeutic intervention specifically targeted to support people with self-harm presentation in ED.
- The therapy incorporates Psychodynamic Interpersonal Therapy (PIT) with elements of Cognitive Analytic Therapy (CAT).

- 98 patient referrals received between 25th May 2018 and 22nd Oct 2018
- 2.0 WTE staff supporting HOPE Service
- 6% (n=4) DNA rate
- **Median number of days for 'engaged' patient referrals to be contacted and offered the HOPE service = 1 day**
- **Median number of 'Contact – Treatment' days for 'engaged' patient referrals = 7 days**

HOPE Service session completion rates for Monthly 'Engaged' Patient Referrals.



HOPE Therapy RLUH: Clinical Update

May 2018 – August 2019

- **92** patients have now completed therapy: 73.6% female, 26.4% male
(Introduction, 5 therapy sessions + follow up)
- *A&E Re-Attendance with self harm: 7.6%*
7 patients have re-attended A&E with self-harm
3 re-attended during therapy: Exceptional life circumstances for each patient,
no re-attendance since (3.3%)
4 re-attended post therapy: 1, 3, 7 and 8 months post therapy (4.3%)
- *A&E re-attendance without self harm: 5.4% (5)*
- Preliminary Analysis of Core 10 and Core 34 data shows clinical changes in improvement in depression, anxiety and in some patients, significant reduction in suicide risk.
- Further evaluation including economic evaluation is planned.

Qualitative Quotes from HOPE Service Users

- *'....it was hard but relieving at the same time'*
- *'(the therapist) was just friendly and she did see me, she was concerned'*
- *'I get out my frustrations and things'*
- *'.....it did make me feel better cause it's understanding myself'*
- *'....the connection with the person, and I just sort of got out what I felt and that stuff I've never talked about in-depth with people....'*

Feedback

- “They told me I would be contacted really quickly and I would be seen within 2 weeks, I didn’t actually believe it though! I couldn’t believe it when Emma called the next day..” (*SD 07/11/2018*)
- “I have really enjoyed coming here, I was really skeptical about therapy, after bad experiences in the past, but I have felt valued and listened to” (*ZM 26/04/2019*)
- “I spoke about my self-harm and suicidal thoughts with another therapy service and was told “we can’t work with you if you have recently self-harmed”. Emma made me feel safe and contained and I was able to talk freely about my self-harm, which actually helped and reduced my urge to do it” (*CC 29/04/2019*)
- “I really value the service you offer. It is aptly named – when I discuss it with patients, it really does engender hope” (*Liaison Psychiatry colleague, 30/04/2019*)

Case Summary 1

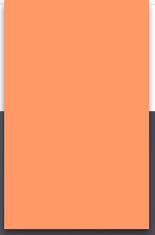
- 40 year old lady admitted with overdose of paracetamol and started on treatment with parvolex on 25th June 2018.
- Parallel Liaison psychiatry review before parvolex treatment is completed on 25th June 2018.
- Referred to HOPE therapy service and contact made by service on 26th June 2018.
- 1st session of therapy on 29th June followed by weekly sessions and completed therapy on 30th August.
- Clinically significant improvement in risk scores and depression scores on CORE 10 measures.
- Returns to work.

Case Summary 2

- 18 year old male was referred to HOPE on 05/12/18 following a mixed, staggered overdose with the intent to end his life. He also restricted eating as a means of self-harm.
- Patient was painfully shy and found it difficult to talk initially, eye contact was minimal and he was visibly anxious and guarded.
- He had never spoken about his feelings in the past and would “bottle everything up”
- A gentle approach was taken and as the sessions progressed and the therapeutic relationship was established, the patient was able to engage well and a sequential diagrammatic reformulation (SDR) was created.
- During our final session (23/01/19), he spoke of how grateful he was for the sessions and how they had “changed [his] life”. As a way of communicating his gratitude, he had written, performed and recorded a piece of music entitled “Thanks, Emma”.
- We listened to this music together at the end of the session.
- The patient also spoke with his mother about his feelings and returned to work. He took a picture of the SDR and carries it with him everywhere he goes.

Crowd sourcing for Learning Set 2

Top Topics



Suicide prevention project and bereavement support service

SOUTH WEST LONDON STP



South West London
Health & Care
Partnership

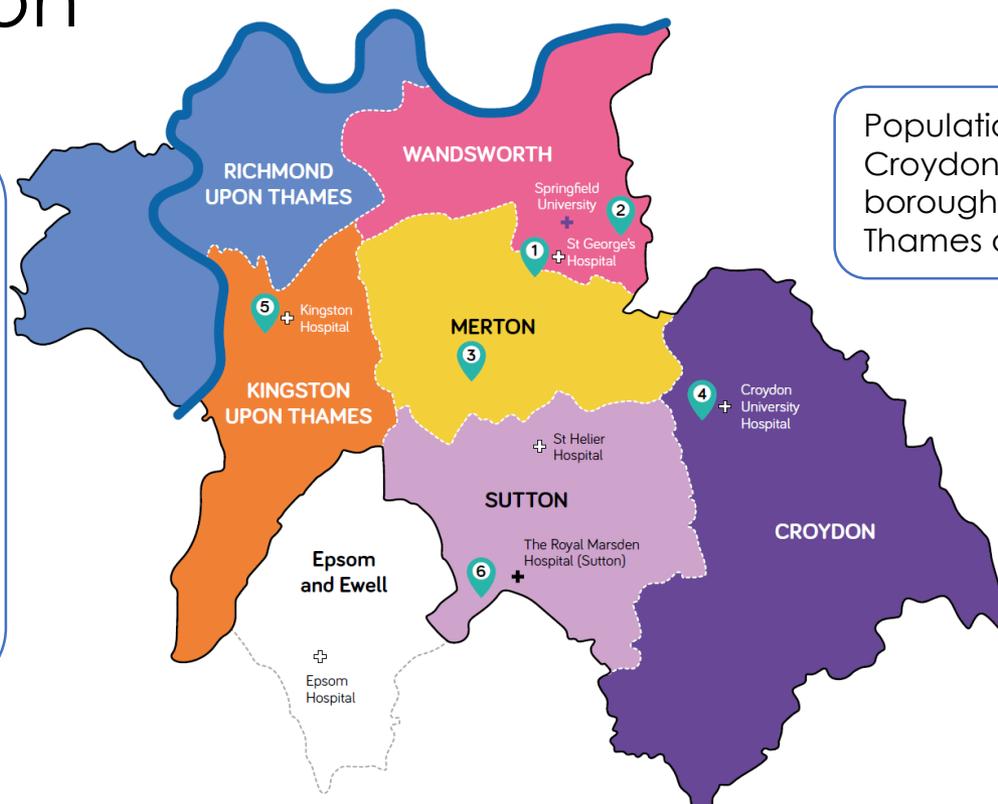
SW London Suicide Prevention Projects

**Prevention in middle-aged men and mobilising
specialist bereavement support**

Leah O'Donovan, Acting Assistant Director – Mental Health

SW London

Suicide rate (persons) of 8.5 per 100k, which is above London average of 8.1 but below England average of 9.6. Our rate amongst men is 13 per 100k, which is above London average of 12.5 but below England average of 14.9.



Population of 1.5million.
Croydon our biggest borough. Kingston upon Thames our smallest

Changing diversity:
Richmond 86% 'white' while Croydon made up of 18 different ethnic categories. Kingston has the largest Korean population in Europe

Targeting middle-aged men

The project is aimed at preventing suicides among middle-aged men and intends to deliver the following:

Outreach in places where men are likely to go, e.g. gyms, sports and leisure facilities, barber shops, bookies and other non-clinical settings

Outreach with a focus on low-income individuals and risk groups, e.g. Job Centres, Citizen's Advice Bureaux and housing association care-takers/ staff

Recruit suicide prevention champions – organisations, individuals, GPs, community pharmacists – across SW London to interact with and support men in the community: friends, family, colleagues, customers, etc.

Commissioning and delivery of a general suicide awareness training programme available to anyone wanting to find out more, including our champions

Development of an information pack/toolkit for champions

Support the development of a men's shed in each borough from which outreach activities and services for men will be delivered

Project evaluation

Through the evaluation we will quantify:

- The numbers of champions recruited
- The numbers of people/organisations trained
- The number and type of outreach activities

We will also measure:

- The impact of the training through feedback from those trained
- General feedback from organisations and individuals involved in the project
- The impact on delivery of men's sheds: existing and newly-developed and range of activities delivered

We will also use the Thrive LDN data hub to monitor numbers of suicide attempts by men over the course of the project and for the year following to ascertain if it has had an impact

Mobilising a new specialist bereavement support service

Develop and employ a part-time Suicide Bereavement Liaison Officer. Key activities of the role will include:

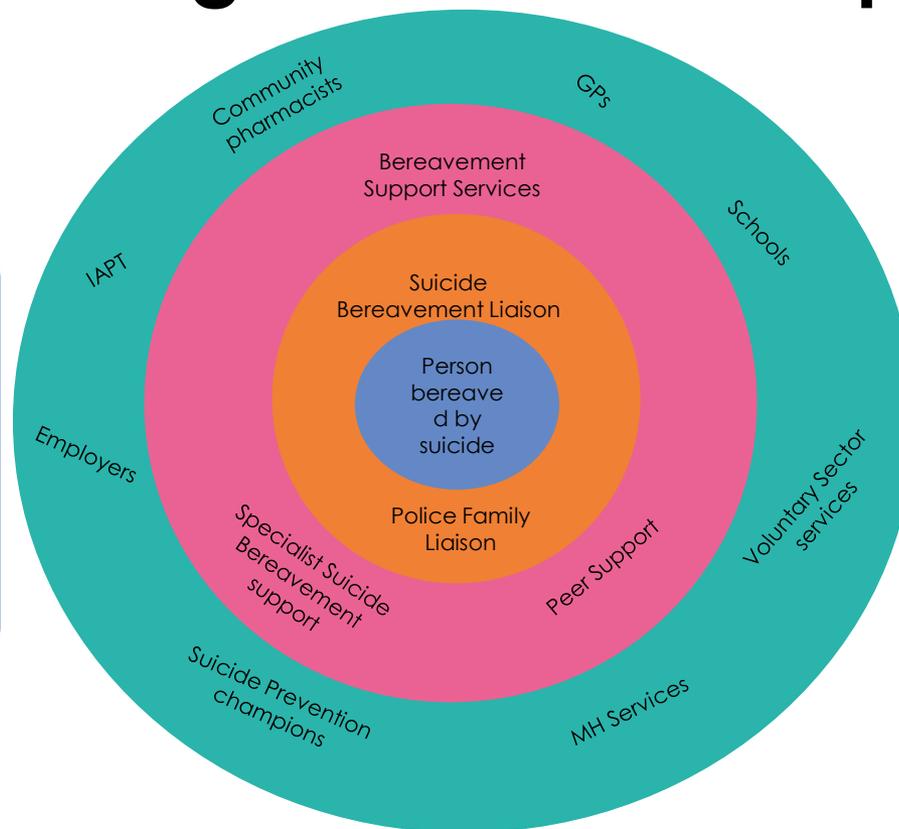
- To receive referrals for support from the police, health professionals and self-referrals
- Make initial contact with the bereaved to offer 1-1 support providing Help at Hand booklet signposting to bereavement support organisations, peer support groups and/ or mental health services for counselling/support
- Advocacy and liaison support during inquests or related meetings that may be part of the process following the suicide
- Longer-term follow up contact e.g. one year later
- Liaising with existing child suicide arrangements, CDOPs, MASHs etc

The Liaison officer will be employed via Mind, reporting within its management structures with the exploration of 'clinical supervision' to be provided externally where not available . The Liaison Officer will report to the Suicide prevention forum

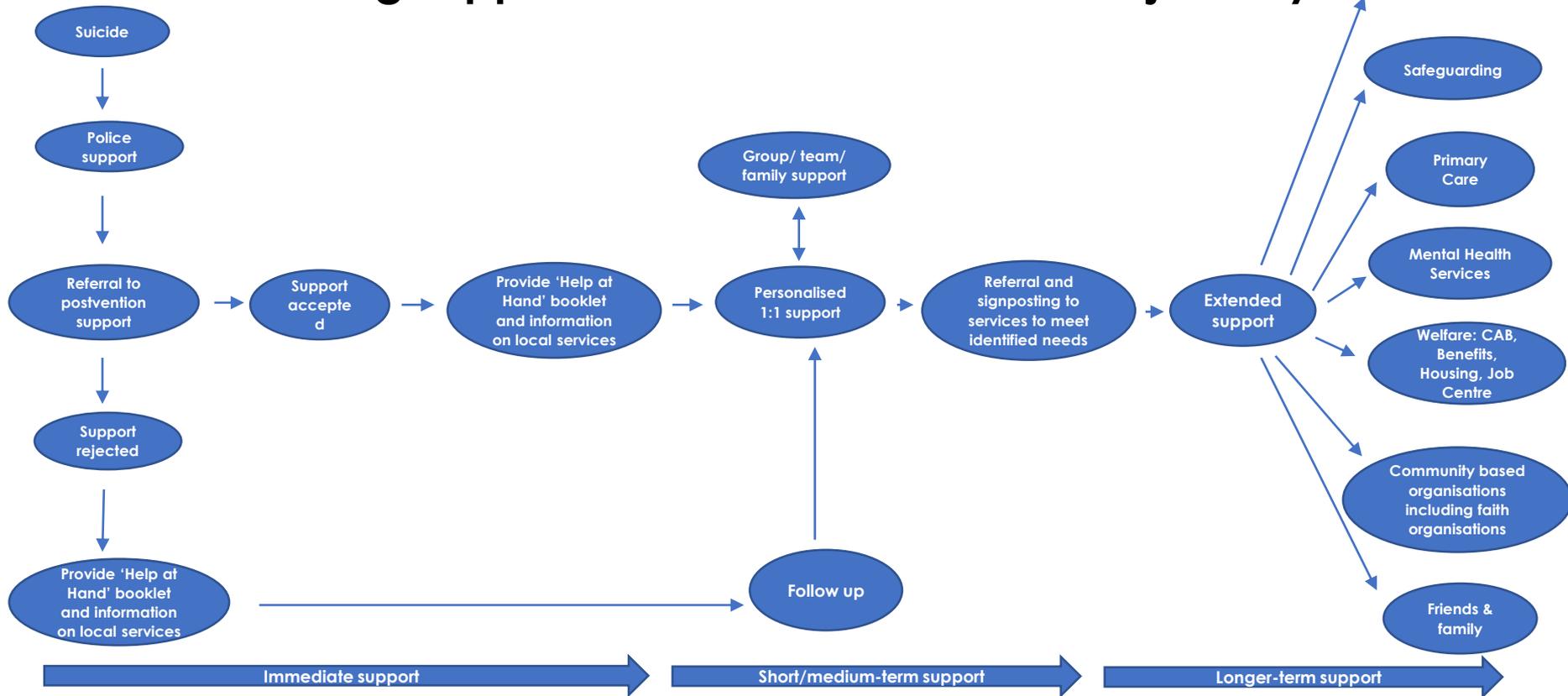
Provide training to bereavement support organisations in supporting someone bereaved by suicide to be able to offer support upon referral via the Liaison officer or self-referrals

Creating a network of support

This represents the network of support that will be available to a person bereaved by suicide as a result of our project – immediate and short-term support up to longer-term and future interactions



Providing support across the bereavement journey



Project evaluation

Through the evaluation we will determine:

- If the capacity of one Liaison Officer is enough for the suicide rate in SW London, including whether additional capacity could include setting up peer support groups and other additional support services
- If the service has provided effective support to those referred
- If the service has made an impact on the wider network of support available to people bereaved by suicide
- If bereavement support organisations feel confident to provide specialist suicide bereavement support going forward
- Ongoing cost of the service as set up

The evaluation will be used to support a business case for recurrent funding

Thank you

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Mindstance and It Takes Balls to Talk

COVENTRY AND
WARWICKSHIRE STP



MindStance

MIND AND CGL WORKING IN PARTNERSHIP

How it came about

- ▶ Suicide prevention - requested
- ▶ Consultations x2
 - First involved 16 people in total, comprised of service users, CGL staff & CW Mind staff; whereby data was collected & analysed, creating a template for the pilot programme.
 - The programme was then collectively written by both organisations
 - Second consultation – the content of the programme was reviewed by service users, with amendments made to better tailor the course to needs. A name was chosen by service users – MindStance was born!

What was this comprised of...

- ▶ Session 1 – What is normal?

This session was comprised of breaking down stigma (self/external) and misconceptions, our own judgements, normalisation of mental health problems and their symptoms, and the shame and blame culture of ourselves and others.

- ▶ Session 2 – What's my condition?

This session was comprised of exploring various mental health conditions, the diagnostic process and what these labels mean for individuals, various treatments (looking at the medical model and the social model), and strategies to manage these.

- ▶ Session 3 – What's my poison?

This session was comprised of looking at the different types of non-prescription drugs and their affects (uppers/downers), psychotropic medications and their impact on individuals when consumed with non-prescription drugs, disassociates, new & emerging drugs and their consequences, treatment for substance misuse and how to manage this.

What was this comprised of...

▶ Session 4 – Why we chose to use?

This was comprised of looking into influencing factors including the socioeconomic, behavioural and biological explanations. This session focused on trauma, and strategies to understand and manage the impact of trauma, including “grounding techniques” and self-care. This session looked at the differences in self-harm methods, and the overlap of self-harm in mental health and self-harming using harmful substances. This session began the process of encouraging an increase of self-esteem through group activities and peer support.

▶ Session 5 – How can I self-help?

This was comprised of coping strategies and theories from the world of problematic substance misuse and mental health. Building on the work completed prior we were able to encourage strategies to encourage self-compassion and what this means. We completed strategies around thinking styles, and looked at ways to challenge these in an attempt to decrease the impact of automatic negative thoughts. The group were given activities for self-directed learning, and we really encouraged the concept of resilience and what this means for the individual.

▶ Session 6 – How can I get involved?

This was comprised of an education of the opportunities available for service users to continue their recovery. The consolidation of skills and lessons learnt was explored, and service users were fully informed of the support that was available. We explored volunteering opportunities in both organisation and we stressed the importance of peer support/mutual aid.

Any difficulties?

- ▶ The problem initially and throughout has been getting the right balance of conversation and education/teaching

Teaching style method v's group therapy – generalisation – doesn't allow for discussion and person-centred approach

Had to adapt - service users stated a benefit from the peer support and therapeutic conversation

- ▶ We noticed that the consistency of attendance became an issue, however service users still shared that this did not impact on the course being of some benefit
- ▶ Time restraints – the courses content was full, therefore it was a struggle to fit everything into a 2 hour session
- ▶ Safe therapeutic space – how do you allow people to share, but not negatively impact on others in the group?
- ▶ How do you make sure everyone is heard?

Outcomes and Recommendations

Of the quantitative feedback received, **50%** of service users showed a significant increase in scores on SWEMWEBS

100% of service users asked stated that they would recommend the course for someone else

100% of service users stated that they would have liked the course to have run for longer

100% of service users reported a positive change in their circumstance and/or recovery

100% of service users shared that the course had educated them about their problematic substance misuse and their mental health

"It was a well received course that was interesting and informative"

"It has helped me with my day to day living, & to stay on the right path"

"I have really enjoyed this group"

"A really good course!"

"I have met an amazing group of people & will use that knowledge to improve my recovery"

"Answered a lot about stigma in mental health which I found very useful & has helped me communicate, causing a positive effect to my own personality"

"I have learnt as much from the service users, as I have from the programme itself"

"A good mix of structured learning & mutual aid"

"I have stuck the positive affirmations to my fridge so I look at them often"

Recommendations...

Time v's content – 70% of service users requested that the course be delivered over 8 weeks rather than 6, to allow time for course content and peer support/mutual aid.

On going practical exercises that would be stretched out across the course/programme

Due to the large varying severities of mental health diagnosis and problematic substance misuse – more nuanced selection criteria would be suggested

100% of service users feel the course is a stand alone course, needed for others, feeling that it needs to continue to be delivered



Thank you, any
questions?

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Metrics Captured

- Event Details (Incl. attendance figures)
- Infinity Cards handed out
- Conversations held (Meaningful and Brief)
- Referral/Information provided to local service
e.g. Samaritans, IAPT
- Crisis Interventions
- Training Feedback
- Social media Reach

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Events

Target	Activity	Likely
<ul style="list-style-type: none">• 24• 24• 4	<ul style="list-style-type: none">• Sports events• Training• Hard to reach	<ul style="list-style-type: none">• 31• 31• 10

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Recent Events

- Warwick Racecourse New Year's Eve event attended by 6000 people
- Suicide Prevention Day event at a Rugby Club
- Coventry University Men's Health Day
- Rolls Royce all 4 shifts
- Two Warwickshire Gyms
- Coventry University Sports event campaigning

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Social Media impact

Aug 2018	Monthly Average	Aug 2019
<ul style="list-style-type: none">• 1027• 2500• 6500	<ul style="list-style-type: none">• Followers• Impressions• Top tweet	<ul style="list-style-type: none">• 2197• 76470• 21800

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