Suicide Prevention Programme
Learning Set 2

4th December 2020

Welcome!

Thank you for joining this National Suicide Prevention event

The event will start at 13:00
Introduction

National Collaborating Centre for Mental Health

Tom Ayers
Housekeeping

• Please mute your speakers/audio unless you are speaking

• Please turn your camera off when others are presenting

• If you would like to ask a question or leave a comment, please use the chat function within the meeting

• If you experience any technical difficulties, please email safetyimprovement@rcpsych.ac.uk

• The presentations and Q&A will be recorded and shared on our website. If following today’s event you do not wish to be identified please contact us on the email above
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<td>12:45 – 13:00</td>
<td>All attendees to join the meeting</td>
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<td>13:00 – 13:10</td>
<td><strong>Welcome</strong>&lt;br&gt;Tom Ayers&lt;br&gt;<em>National Collaborating Centre for Mental Health</em></td>
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<td>13:10 – 13:40</td>
<td><strong>Latest findings on self-harm and suicide prevention, including COVID-19</strong>&lt;br&gt;Professor Nav Kapur&lt;br&gt;<em>National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)</em></td>
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<td>13:40 – 14:05</td>
<td><strong>Positive impact of multiagency working in the community; responding to COVID 19</strong>&lt;br&gt;Wellbeing and Mental Health During COVID 19 Booklet – a guide to looking after yourself and others&lt;br&gt;Katherine McGleenan – NE&amp;NC SP Network lead&lt;br&gt;Chris Wood – Every Life Matters&lt;br&gt;<em>North East and North Cumbria ICS</em></td>
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<td>14:05 – 14:30</td>
<td><strong>Domestic abuse and suicide prevention</strong>&lt;br&gt;Tim Woodhouse&lt;br&gt;<em>Kent and Medway STP</em></td>
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<td>14:30 – 15:00</td>
<td><strong>Interactive quality improvement session on large-scale change</strong>&lt;br&gt;Dr Helen Smith&lt;br&gt;<em>National Clinical Director for Mental Health Safety Improvement Programme</em></td>
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NCISH Update

Professor Nav Kapur
National Confidential Inquiry into Suicide and Safety in Mental Health

STP Learning Day
Latest findings on self-harm and suicide prevention, including COVID-19
4th December 2020

Professor Nav Kapur
Figure 1: All persons, males and females saw increases in suicide rates in 2019

Age-standardised suicide rates by sex, England and Wales, registered between 1981 and 2019

Age-standardised suicide rate per 100,000

Year of death registration

Persons  Males  Females
Suicide risk assessment in UK mental health services: a national mixed-methods study

Jane Cope, Nicola HonN, Luth Jacobs, Catherine Aikinfaba, Paula Petrelli, Anthony Geraci, Louis Appleby, Nick`tighe

Summary

Background: Risk assessment is a central component of mental health care. No national studies have thus far been done in the UK on risk assessment tools used in mental health services. We aimed to examine which suicide risk assessment tools are in use in the UK, establish the views of clinicians, patients, and service users on the use of these tools, and identify how risk assessment tools have been used with mental health patients before suicide.

Methods: We did a mixed-methods study involving three components: collection and analysis of risk assessment tools used in UK mental health services, an online survey of clinicians, service users, and carers; and qualitative semi-structured interviews with clinicians on their use of risk assessment tools before a suicide death and their views of these tools. The online survey was advertised through the National Confidential Inquiry into Suicide and Safety. The Mental Health (NHS) database and social media, and included both quantitative and qualitative questions, and respondents were recruited through convenience sampling. For the telephone interviews, we identified the SCSU database to identify clinicians who had been responsible for the care of a patient who died by suicide and who had been involved in the investigation.

Findings: We obtained 10 risk assessment tools from all 84 National Health Services mental health organisations in the UK, and 10 (one per each organisation) were included in the analysis. We found little consistency in use of these instruments, with 11 (61%) of 18 organisations using health development web. Most tools aimed to predict withdrawal of treatment (85% of UK), and scores were used to determine management decisions (63% of 63%). Clinicians described positive aspects of risk tools (facilitating communication and enhancing therapeutic relationships) but also expressed negative views (haphazard training in the use of tools and their time-consuming nature). Both patients and carers reported some positive views, but also emphasised little involvement during risk assessment, and a lack of clarity as to what was done in a crisis.

Interpretation: Assessment protocols need to be consistent across mental health services and include adequate training on how to access, formulate, and manage suicide risk. As an endpoint on patient care involvement is needed. Care with national guidance, risk assessment should not be used as a way to predict future behaviour and should not be used as a means of withholding treatment. Management plans should be personalised and collaboratively developed with patients and their families and carers.

Funding: The Healthcare Quality Improvement Partnership.

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Introduction

Each year, about 1000 people in the UK die by suicide and little has been done to reduce this figure. The role of mental health care in preventing suicide has been established, and a key component of clinical practice internationally is the management of risk. The use of structured risk assessment scales is common.

Research suggests that evidence of the effectiveness of risk tools in predicting suicide or self-harm is limited. The predictive ability of such tools varies widely. Few perform sufficiently well across multiple indices of diagnostic accuracy to be recommended as clinical tools, and some evidence suggests that most suicide risk tools perform no better than simple clinical or passive guessing. Is the use of these scales that many patients are appropriately classified as being at high-risk (false positive) or, more importantly, some patients who go on to harm themselves die without being relatively safe? (false negative). Clinical guidance in England, Australia, and New Zealand do not recommend the use of risk assessment scales to predict suicide or self-harm, nor to determine the course of treatment offered to individuals and their families should be undertaken to inform a management plan. However, this view is not universal, and some countries, such as the USA, advocate widespread use of risk stratification and assessment instruments. Various studies on the use of risk assessment tools for suicide assessment, with limited research on the use of risk assessment tools for suicide assessment, with limited research on the use of risk assessment tools for suicide prevention, are needed to determine which proposals are most effective.

https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30381-3/fulltext
Content and Format of tools

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Content and Format of tools

156
Risk assessment

https://www.youtube.com/watch?v=DUmvLnAc1Lo&feature=youtu.be
Support for self-harm

The NHS Long Term Plan

Manage Self-Harm

Support for improving community-based care for self-harm

http://www.mash.bmh.manchester.ac.uk/improving-community-based-care/
Clinically Significant mental distress

- 2018/19
- Apr-20

Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population

Summary

The personal impact of the COVID-19 pandemic on population mental health is of increasing global interest. The pandemic has had a significant impact on the mental health of the UK population both during and after the lockdowns. This study aimed to examine the changes in mental health symptoms in the UK population before and during the COVID-19 pandemic, using a longitudinal probability sample survey of the UK population. The study found that the prevalence of clinically significant mental distress increased significantly during the pandemic, with a peak in April 2020. The study also found that the prevalence of mental health symptoms varied by age, gender, and socioeconomic status. The results of this study provide important insights into the impact of the COVID-19 pandemic on mental health and highlight the need for continued support and resources for mental health during the pandemic and beyond.
The Iceberg Model of suicidal behaviour

- Suicide
- Self-harm presenting to services
- Self-harm in the community
Child suicides may have increased in first 56 days of lockdown

Numbers too small to reach definitive conclusions

Restriction to education & other activities, disruption to care & support, tensions at home & isolation appeared to be contributing factors
Fig 1: RTS findings

Total population: 9m
2020 monthly average
Pre-lockdown: 84.0
Post-lockdown: 85.4
April-August 2020 + 7.3%
ECDS data on self-harm

Total self-harm presentations to the Emergency Department in two Manchester Hospitals

(With thanks to Caroline Clements)
Hospital data on self-harm

Primary care data on self-harm

Other sources of help


https://mental.jmir.org/2020/11/e22984/
The impact on self-harm and suicidal behaviour

Ongoing (‘living’) systematic review

No evidence of an increase in suicide, self-harm, suicidal behaviour, or suicidal thoughts

Factors associated with suicide include: fear of infection, social isolation and economic concerns

Source: John et al. (2020)
https://doi.org/10.12688/f1000research.25522.1

https://www.bmj.com/content/bmj/373/bmj.m4352.full.pdf
COVID-19: local multi-agency suicide prevention

Support for:
- Isolated
- Bereaved
- Victims of domestic abuse

Community:
- Enhance social capital
- Green space

MH Services:
- Access
- Crisis/self-harm
- Maximise digital CAMHS, esp ASD/ADHD

Partnership with:
- 3rd sector
- Local media

Data:
- Real Time Surveillance
Positive impact of multiagency working in the community: responding to COVID-19

Wellbeing and mental health during COVID-19 booklet - a guide to looking after yourself and others

Katherine McGleenan - Suicide Prevention Network lead
Chris Wood - Every Life Matters

North East and North Cumbria ICS
Positive impact of multi-agency working in the community: responding to COVID-19

Wellbeing and Mental Health During COVID-19 booklet – a guide to looking after yourself and others

Katherine McGleenan – NE&NC SP Network Lead
Chris Wood – Every Life Matters
Outline of the presentation

• Network **response to the pandemic.**
• Developing the **booklet.**
• Widening the **impact.**
• **Multi-agency working** – making it work.
• Next steps – **building on success.**
Aim of the session

• To show how we went from the idea of the booklet to distributing to over 1.3 million homes in approx. 8 weeks.
The NE&NC Suicide Prevention Network
NENC Suicide Prevention Network
Structure — August 2020

ICS Mental Health transformation programme steering group
SP Network Lived experience reference group — NSPA
SP Network Clinical advisory group
programme support — Northern England Clinical Networks, AHSN, regional university partners.

ICS work stream sponsors
ICS suicide prevention Lead
ICS SP core leadership team
ICS SP plan 2019-24

Zero Suicide Ambition / national suicide prevention programme leads - ZSA/NCISH/NHSE/I/Samaritans media team/NICE
North Region programme support (NHS England, PHE)
Sector led improvement

ICS multi-agency priority workstream implementation group & Locality level implementation groups

Developing Safer communities

North ICP leadership team / steering group & implementation plan
South ICP leadership team, steering group & implementation plan
North Cumbria ICP leadership group & implementation plan
North Cumbria (i Copeland, Allerdale, Carlisle & Eden)

Developing Safer services

Northumberland
Newcastle
North Tyneside
Gateshead
South Tyneside

Sunderland
County Durham
Darlington
South Tees (incorporating Hartlepool, Stockton, Middlesbrough, Redcar & Cleveland)
North Yorkshire (incorporating Hambleton, Richmondshire & Whitby)
Whole system approach
Reviewing our priorities in response to COVID-19
Increase in known risk factors

- Adverse childhood experiences (ACEs)
- Previous suicide attempt(s)
- Mental disorders, particularly clinical depression
- Alcohol and substance abuse
- **Isolation**
- Most people take their own life **at home**
- **Loss (bereavement, social, work, or financial)**
- **Physical illness**
- Easy access to methods
- Poor help-seeking due to stigma
- People in the **lowest socio-economic** group living in deprived areas.
Potential COVID impact/unknown risk

- Reduced access - perceived or real
- Reduced help-seeking – message to stay away
- People told to stay at home
- Unknown emerging high risk groups
- Everyone may be effected/impacted
- More vulnerable people may not have digital access.
  People may be confused/overwhelmed.
Priorities from people with lived experience

- Help needed **sooner**.
- **Raise awareness**/train people.
- More **information** is needed.
- **Families** more involved.
- Support for **people affected**.
- **Work together** — integration.
- Help reduce **stigma**.
Refocusing and adapting our priorities for direct impact

- PHE real time surveillance (RTS) pilot
- Contingency for postvention support
- Adapting training packages
- Media and social media campaigns
- Support more grassroots/suicide safer communities
- Increase access to information and resources.
The idea

• Immediately clear this would be challenging to our communities’ mental health, particularly vulnerable West Coast districts.
• People would be looking for guidance to navigate uncharted territory.
• Could see benefit of paper materials with NHS endorsement.
• Opportunity to engage large amounts of people with direct suicide prevention messages at a time of national emergency.
• Many people who could support the idea that had now had their ordinary work cut off i.e. printers, distribution and design.
Developing the booklet

From first idea to first doorstep in 18 days

17th March  Began writing the booklet – day after Government recommends stopping social contact.

24th March  First draft of text produced – day after national lockdown begins – and bid submitted to NENC Suicide Prevention Network.

27th March  First graphic design draft produced + funding agreed.

31st March  Consultation on booklet content complete and final edits made.

4th April   First 50,000 (of 200,000) booklets delivered.

5th April   Distribution begins in Allerdale next morning.
Developing the booklet

From first idea to first doorstep in 18 days

8th April  2nd phase of funding agreed and 50,000 more booklets produced.

14th April  Generic version of the booklet produced for use across North East and other areas.

19th April  Funding secured and 60,000 booklets produced for South Cumbria supported by County/District Councils and Royal Mail distribution.

14th May  Distribution of 120,000 booklets across North Cumbria complete.

19th May  23,000 booklets delivered by volunteers in Barrow.
Wellbeing and mental health during Covid-19:
A guide to looking after yourself and others

Contents

3 Looking after yourself
4 Beating corona anxiety
5 Manage your stress bucket
6 Looking after your wellbeing
9 Struggling to cope
11 Wellbeing plan
14 Jar of hope
15 Supporting young people
16 Work well from home
17 Looking out for others
18 Five steps to helping others
19 Spot the signs
20 Listening tips
21 Thoughts of suicide
22 Getting help
Struggling to cope

Thoughts of suicide are not uncommon - a lot of people will have them - around one in five of us during our lifetime. Having these thoughts doesn’t make it inevitable that you are going to take your own life.

If you are having thoughts of suicide focus on what you need to do to keep yourself safe for now. Visit www.every-life-matters.org.uk to complete a Safety Plan and learn more about what practical steps you can take to keep yourself safe. This can include:

- Finding ways to distract yourself that allow the feelings to pass
- Calling a helpline or someone you can trust
- Avoiding using alcohol and drugs
- Removing things from your house that you could use to harm yourself
- If you can, going somewhere you feel safe
- Knowing who you can contact if you need professional support - this might be your key worker, your GP, NHS 111 or others
- Making a Hopebox - a list, or photos, or objects that remind you of why you want to live.

If you feel you can’t keep yourself safe any longer, or if you have done something to harm yourself - call 999 now. The number is free.

Thoughts of suicide do pass and there are things that you and other people can do to make your situation better.

Thoughts of suicide

Being there to listen and to provide emotional support can be a lifesaver.

If you’re worried that someone you care for may be feeling suicidal it can be really hard to know what to say to them, or how to help. But thinking about suicide does not make it inevitable that someone is going to take their own life, and all of us have the ability to support someone who is experiencing thoughts of suicide, and to save lives.

Trust your gut instincts. If you are at all concerned that someone is having thoughts of suicide - ASK them directly - LISTEN compassionately - GET HELP if needed.

In addition to the general signs of mental health problems listed earlier someone having thoughts of suicide might:

- Talk, or post social media messages, about wanting to die, feeling hopeless, trapped or having no reason to live, or that they are a burden to others.
- Show unexpected mood changes such as suddenly being calm after a long period of depression, giving away possessions or making a will, increased risky behaviour or self-harming, or researching suicide online.
- Have had a major loss or change in their life, an accumulation or build-up of problems before Covid-19, or be facing financial, relationship or housing hardship.

Talking about suicide with someone can feel nerve-wracking but the best thing to do is ask directly. “Are you thinking about suicide?” This will not put ideas in their head and will show them they don’t have to struggle alone with these overwhelming thoughts.

Visit www.every-life-matters.org.uk for more information on how to help someone with thoughts of suicide.
Distribution during a lockdown

- Distribution partner found for Allerdale, Copeland and Carlisle.
- Royal Mail appointed for Eden, super sparse rural district.
- Small army of volunteers came forward to fill in the gaps and deliver a further 11,000 booklets.
- 23,000 copies delivered entirely by volunteers in Barrow.
- Booklet distributed electronically very widely, including all workforce of Sellafield and BAE.
Feedback on the booklet

• It is consistent with CBT principles and offers a multi-modal approach to self-help. - Psychologist

• A physical copy just sitting there can be dipped into & more easily accessible. - Member of public

• Someone might read the booklet while having a coffee & know there is help out there. - Retired GP

• I think the link to the MIX is really good. It is really accessible and has so many great resources and has advice on loads of different subjects and has a very friendly feel to it. – Student, age 22
Widening the impact across the region

- April – **Wider funding agreed.**
- April – **regional version** of the booklet developed.
- April – May – **distribution planning.**
- May - MH Awareness Week **press launch.**
- Mid/end May – **1.3 million booklets distributed**
What helped us implement quickly?

- **Lived experience** at the heart of what we do.
- Shared **vision** and **values**.
- **Action focus**
- **Equal partnership** - shared leadership/trust.
- **Relationships/connections** - picking up the phone.
- **Networking** & engaged communities.
- A semi-structured approach – **being flexible**.
Some of the people involved in making it happen

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<td>Bereaved families and friends</td>
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<td>Designers/printers</td>
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<td>Members of public</td>
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<td>NHS Clinical Leads</td>
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<td>Distribution companies</td>
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<td>NHSE/PHE</td>
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<td>Local community groups (churches, resilience hubs)</td>
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<td>Local press/communication teams</td>
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The McKinsey 7S Model – a structured approach
What were the barriers?

- Organisations different priorities.
- Organisational hierarchy.
- Focus on short term.
- Information & guidance overload.
- Perception of needing to wait for permission.
- Risk averse culture - fear of getting it wrong.
Ben

“Please just do something”

April 2018, Kate – Ben’s mum
Next Steps regionally and locally.....
Shared Network messages

• **Suicide is preventable** – *everyone can help*

• **Look after yourself**

• **Look out for others**

• **Get help early**
Every life matters...

6,507 people in the UK died by suicide in 2018. This is 3 times the number of people who died on our roads every year.

On average we lose one person to suicide each week in Cumberland. Suicide rates are around 30% higher than the national average, with the highest rates along the West Coast and Barrow.

1 in 17 of young people have thoughts of suicide every year, with a staggering 1 in 5 of us having thoughts of suicide in our lifetime. The majority of people who have thoughts of suicide and the situation that has caused them.

Suicide is the leading cause of death of men under 50, 75% of which are self-inflicted and most by the highest risk group.3

Each 300 school children die by suicide every year. Suicide is the leading cause of death in young people under 25 years old.

Only 20% of people who die by suicide have had contact with mental health services in the year before they died. Suicide prevention needs to be a community-wide concern. It is family, friends, neighbours and strangers who are best placed to know when someone is at risk.

Young People and Suicide

Supporting a child or young person with thoughts of suicide is something that no doubt sends ripples of anxiety through parents. Starting that conversation can feel a daunting prospect but it could potentially be the biggest step forward. It’s vitally important to know how you can help if your child is having thoughts of suicide.

Look out for changes in mood and behaviour

- Distressed or withdrawn from friends and family
- Phobias or sleep patterns
- Loss of interest in activities
- Verbalisations about suicidal thoughts

If you’re worried about them, it is ok to ask directly “Are you thinking about suicide?”

What if they say YES?

If you think your child is experiencing the thoughts of suicide, the most important thing that you can do is to stay calm. Acknowledge how difficult this must be for them to talk about and let them know you are here to listen.

How do I help?

- You won’t say the wrong thing but bring more to that moment is good. You care and you are a safe person to talk to. Don’t worry about what you should or shouldn’t say just listen.

- Connect and let them know how brave they are and that you are here to help.

In partnership with Ewanrigg Local Trust, Every Life Matters and #safelivesathousandthoughts

Having thoughts of suicide?

Contact your GP or the nearest A&E. If you don’t feel you can keep yourself safe or someone call 999 straight away.

Nobody should have to struggle alone. Taking care of yourself is the first step.

Where to go for help:

Suicideline 24hr support. Call 116123.
CAGLAI Mental health helpline for men 1pm-9pm. 0800 558823
YoungMinds helpline for young people 10am-10pm on weekdays, 10am-10pm weekends 0300 123 5678
SHOUT24crisis text service. Text SHOUT to 85258
Young Minds Text line service for young people. Text YM to 85258
Outlive24 hr phone support for under 18s. 0800 370 370
Silverline 24hr support line for older adults. 0800 678 9209
Young Minds ParentLine Support and advice for parents. 0800 862 1664
Cumbria NHS Foundation Mental Health support line 8.30am-10am, 0300 550 1000
For more information about where to get support, or how to support someone experiencing thoughts of suicide, visit www.every-life-matters.org.uk

Proud to support this edition!

In partnership with Ewanrigg Local Trust, Every Life Matters and #safelivesathousandthoughts

Marryport Matters

MARRYPORT STAYS AT HOME
Be helpfully nosy

Sometimes it's hard for people to open up about their problems.

If you are worried about someone - ask twice, be patient, be helpfully nosy.

Listening can be a lifesaver

The smallest acts of kindness - like picking up the phone and offering a listening ear - could make all the difference to someone struggling during the Covid-19 crisis.

Help support......

World Suicide Prevention Day
10th September

Order a FREE paper/digital resource pack today
ELM Advent Talking Heads
Every life matters...

every-life-matters.org.uk
everylifecumbria
@Every_Life_Cumb
EveryLifeCumbria
Domestic abuse and suicide prevention

Tim Woodhouse

Kent and Medway STP
Highlighting the relationship between domestic abuse and suicide

Megan Abbott, Suicide Prevention Project Support Officer,
Megan.Abbott@kent.gov.uk

Tim Woodhouse, Suicide Prevention Programme Manager,
tim.woodhouse@kent.gov.uk

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.
It is a tragic truth that domestic abuse can lead to deaths by suicide of the **victim**, the **perpetrator**, and also of **children** that live in abusive households.

We know this because these deaths form the basis of multi-agency and serious case reviews every year (Domestic Homicide Reviews, Child Death Review Panel reports etc).

Professional curiosity amongst the Kent and Medway Suicide Prevention Team led us to consider whether we had a bigger problem in Kent than other parts of the country or when compared to the national average.

However, a literature review (of journals and data sources) found that no one knows how many people die by suicide after having their lives impacted by domestic abuse.

We have undertaken a series of mini research projects to try and understand the scale of the issue, with the ultimate goal of trying to find ways to reduce the risk of unnecessary deaths.

This presentation sets out the findings, and recommendations of the research projects, and highlights the many unanswered questions.
Published research or statistics relating to suicide and domestic abuse

Not a lot has been published – and what there is, is quite old


- Aitkin, R & Munro, V (2018) *Domestic Abuse and Suicide: exploring the links with Refuge’s client base and work force.*


So we concluded we needed to do our own research, using the data sources that we have access too.
Research project 1: We explored levels of suicidality amongst victims and perpetrators of DA by looking at 928 DASH risk assessments

- 63% of DA victims were feeling depressed or having suicidal thoughts
- 61% of abusers had threatened or attempted suicide

Research project 2: We undertook a major analysis of all publicly available Domestic Homicide Reviews. (93 DHRs between 2016 and summer 2020)

- Over a quarter (26%) contained a suicide
- 10 suicides were completed by the victims,
- 13 suicides were completed by the perpetrator, and were classed as murder/suicides

Research project 3: In partnership with University of Kent we undertook a thematic analysis of suicides amongst children in Kent

- It found that “adverse childhood experiences related to familial domestic abuse and parental conflict… are present {in some of the deaths by suicide considered by this study}”
Research project 4: Early indications from local Real Time Surveillance

• We have 11 months of detailed real time suicide surveillance data so far

• There are indications that the proportion of domestic abuse related suicides could be even greater than we expected

• It is too early to include figures here but we will be doing a full report once we have 12 months of data

• These deaths are made up of four main cohorts;
  1. Victims currently experiencing abuse (female and male)
  2. Individuals who have been victims of domestic abuse in the past
  3. Children and young people living in households impacted by DA
  4. Perpetrators of domestic abuse (either convicted or under investigation)
Cohort 1 Why do victims of domestic abuse feel suicidal? (80 seconds)

Video clip – please use the Youtube link below

https://youtu.be/mhK5qIIXS7M
Cohort 2 Does the suicide risk for victims extend after the direct abuse ends? (90 seconds)

Video clip – please use the Youtube link below

https://youtu.be/Pn7WEx57R8M
Video clip – please use the Youtube link below

https://youtu.be/E8CSXavX40M
Is it a surprise that our local Real Time Suicide Surveillance is also highlighting that perpetrators are dying by suicide? (120 seconds)

Video clip – please use the Youtube link below

https://youtu.be/0bvtKF0jUuA
Discussion

We believe that our research has demonstrated the link between domestic abuse and *feeling* suicidal.

We also believe we have also demonstrated that *lives are being lost by suicide* after being impacted by domestic abuse.

But so many answers still remain that we can’t answer from our local position…
But so many unanswered questions remain…

1. **How many victims of domestic abuse die by suicide nationally (both during the abuse, or in the months and years that follow)?**
   - Are any groups at higher risk (gender? LGBTQ+? Age?)
   - Are there any high risk points within the abuse cycle?
     - Eg when a victim is informed the perp is being released from custody?
     - Or long after the abuse has stopped?

2. **How many perpetrators of domestic abuse die by suicide nationally?**

3. **How many children living in households impacted by domestic abuse are dying by suicide nationally?**

   There are existing data sources which could be used to help answer these questions
   - National RTSS
   - Unpublished DHRs
   - National Child Mortality Database
     - NCISH

4. **What is the true scale of the issue in Kent and Medway?**

5. **What interventions could reduce the risk of deaths by suicide?**
Despite the unanswered questions, we are already looking to take action

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<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health and suicide prevention training completed by all domestic abuse staff. (This is becoming a commissioning condition).</td>
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<tr>
<td>2</td>
<td>Domestic abuse training completed by all mental health staff. (Looking to make this a commissioning condition where possible).</td>
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<td>3</td>
<td>Specialist domestic abuse councillors to be made available for all MARAC victims</td>
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<td>4</td>
<td>Ensure provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped</td>
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<td>5</td>
<td>Ensure provision of perpetrator programmes for both men and women</td>
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<td>6</td>
<td>Undertake further research</td>
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<tr>
<td></td>
<td>• Qualitative research with victims</td>
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<tr>
<td></td>
<td>• Detailed analysis of RTSS</td>
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<tr>
<td></td>
<td>• Detailed analysis of data held by secondary MH trust</td>
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The Suicide Prevention Programme funded Oasis, to pilot their ‘Understanding trauma’ programme for DA Survivors

The psychoeducational groupwork programme helps individuals understand how brains react to trauma. The ultimate objective is to offer participants practical self-care advice and coping mechanisms.

The programme consists of six workshops (each two hours long) and works with 10 survivors of domestic abuse at a time.

A two-day training course is being developed to train other practitioners to deliver this groupwork.

By engaging other professionals this trauma knowledge will be shared and the content can be delivered across Kent and Medway in many contexts and settings.
We asked Oasis how the group is helping “Alison” who survived many years of abuse.

Iona explained that the group helps “by celebrating the fact that she has survived and by helping her learn new tools to deal with the trauma she experienced for many years. It helps her to understand her reactions and feel more in control. It helps her take on hard days in a different way, making them less bad and less often.”
Quality improvement and large scale change

Dr Helen Smith

National Clinical Director for Mental Health Safety Improvement Programme
Top Tips for Scale Up and Spread...... creating a little curiosity

Helen Smith
National Clinical Advisor MHSIP
How can I get all these people to do what I want them to do?
How can I help all these people to do what they want to do?
I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.

*Maya Angelou*
If you want to spark change, feeling is the fuel.

Find the feeling & show visible progress.
Adoption Theory
diffusion curve (rogers)
attributes that facilitate adoption (rogers)

- Relative Advantage
- Compatible
- Simple
- Trialable
- Observable
Expanding Impact
Levers for Expanding Impact

**HERE (TODAY)**
- Publications
- Trainings
- Conferences
- Websites
- Apps
- Earned media
- Social media
- Thunderclaps
- Meet-ups
- Podcasts
- Editorials
- Speeches
- MOOC’s
- Blogs
- Lit drops
- Canvassing

**AWARENESS**
- 1-1 connection/relationships
- Social referencing
- Empathy
- Recognition
- Compelling evidence
- Stories/inspiration
- Fun
- Autonomy
- Invitation (something historic)
- Collaboration
- Competition
- Career advancement
- Payment
- Policy
- Transparency
- Regulation
- Punishment
- Discontent
- Crisis

**WILL**
- Commercialization
- Political advocacy
- Sprint
- Network riding
- Fishbowl
- Breakthrough series
- Collaborative communities of practice
- Extension agency
- Gamification
- Grassroots organizing
- Incident command
- Innovation competition
- “Wedge and spread”
- 90 Day Project

**BEHAVIOR CHANGE**
- THERE (AIM)
Awareness Raising Methods

- Publications
- Training
- Conferences
- Websites
- Apps
- Earned Media
- Social Media
- Thunderclaps
- Editorials
- Speeches
- MOOCs
- Blogs
- Literature Drops
- Canvassing
- Podcasts
- Meet ups
Will Building Methods

- 1:1 connections/relationships
- Social referencing
- Empathy
- Recognition
- Compelling evidence
- Meaning/Inspiration
- Fun
- Autonomy
- Invitation to join
- Something Big/Historic

- Collaboration
- Competition
- Career advancement
- Payment
- Policy
- Transparency
- Regulation
- Punishment
- Discontent
- Crisis
Behaviour - Change Supports

- Collaboratives
- Network improvements communities
- Campaigns
- Extension Agencies
- Franchising
- Gamification
- Innovation Challenges
- “Wedge and Spread”
- Network riding
- Exchanges
- Commercialisation
- Political Advocacy
- 90 day Projects
- Sprints
- Fishbowl
So What about Me?
The "Openness-to-Inner Discovery" Scale

Are you willing to shift from focusing on "what's wrong?" and using your interactions to continue to improve yourself? This handout is designed to accompany you on the journey to connecting deeply with yourself and focusing on discovery so that you can continue to expand into deep presence, expanded connection with the world and more genuine play.
+10 Getting open to creating playmates for support, shifting, expanding essence
+9 Turning your experience into creative expression
+8 Letting your body wisdom directly influence your choices and actions
+7 Matching—letting your words and gestures closely describe your inner experience
+6 Loving yourself for your right-now experience
+5 Appreciating the message(s) that your body is communicating even if the language isn’t clear
+4 Following sensations with your awareness as they move around your body
+3 Breathing with your inner experience
+2 Turning your curious attention fully toward your body sensations and inner experience
+1 Choosing to experience your body experiences as your ally

**Shift Move: Choosing Wonder and Connection**

-1 Asking “why?” figuring it out and other head-centric strategies
-2 Ignoring and/or overriding a body-based impulse and/or intuition
-3 Focusing on “what if...?” and “if only...”
-4 Imagining a different future instead of noticing what’s true now
-5 Comparing body sensations/inner experience to some time in the past or someone else’s experience in the present
-6 Stuck in funk—recycling the issue over and over
-7 Doing the inner triangle dance of criticizing yourself, feeling helpless and fixing or improving yourself
-8 Distracting yourself (food, getting busy, noticing what needs fixing, etc.)
-9 Looking for approval, validation, esteem, decision-making from others
-10 Attacking yourself for your experience