Suicide and Self-harm in young people
risk factors and interventions

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Suicide and Self-harm

**Suicide**
- *The action of killing oneself intentionally*
- *Suicidal thoughts*; from fleeting ideas to preoccupation to plans and attempts. *Suicidal behaviour* (suicide, attempted suicide, deliberate self-harm, Fox 2004),

**Self-harm**
- *self-injury or self-poisoning intentionally to causes harm*
- *an act with non-fatal outcome, in which an individual deliberately initiates a behaviour that, without intervention from others, will cause self-harm…*(World Health Organization)*

*Both are major public health problems in adolescents*

**Can be related or unrelated**
- Some people self-harm with no intention of taking their life.
- Some people take their own life with no hx of self-harm.

**BUT**
- People who self-harm are at increased risk of suicide (Cooper et al. 2005) they are 100 times more likely to commit suicide on purpose or accidentally.
- At least ½ of people who die by suicide have a history of self-harm (and ¼ have been treated in hospital for self-harm in the preceding year).
- Risk is increased in those repeating self-harm and who used violent/dangerous methods of self-harm (Runeson et al, 2010)
The size of the problem – young ppl

1,103 deaths in 2011
(1) hanging, (2) poisoning (3) jumping
(2) 844 male 249 female

220,000 (adult) in 2011
Mostly self-poisoning

Estimates around 1,760,000 (adult)
(1) Cutting (2) self-poisoning

Figure 1: Representation of the relative prevalence self-harm and suicide in young people (Hawton et al, 2012)
Self-harm: What is it?

Self-harm is:
• An expression of **personal distress**
• A way of **coping**
• A particularly adolescent problem
  • studies show a peak in mid adolescence (Hawton, Saunders & O' Connor, 2012)
  • The majority of people who self-harm are 11-25 yrs old (Mental Health Foundation, 2006)
• Very common in young ppl (but largely hidden)
  • 7% -14% of adolescents will self-harm at some time (Hawton, 2005) 12-20% (Whitlock, 2012)
  • 70% of 15-16 year olds across Europe admitted to self-harming (Madge 2008; 2011 CASE study 2005)
• On the rise in young people
  • since 1960s but esp in girls since 1990s.
  • availability of meds / increased stress / greater alcohol and drug?
• A concern for young people
  • It’s the number one issue that young people are concerned about (81%) (YoungMinds survey)

Self-harm is not:
• a mental illness
• a cry for attention
• the same as being suicidal
• something people do for fun
• a fashion thing
• just part of certain sub-cultures ‘goth / emo’ etc
### Risk factors for self-harm

#### Biological
- **Being young**: neurodevelopmental stage of adolescence? Emotional distress and impulsivity higher (Hawton, 2012)
- **Females** (though a lot more males than was previously thought)
- **Family link**: Self-harm is more likely if a family member has previously self-harmed or attempted suicide (CAMHs handbook)

#### Psychological
- **Mental health link**: (48%-57% of hospital admissions for self-harm) depression, anxiety, eating disorders, psychosis, OCD or personality disorders.
- **Poor parent-child attachment** (Fergusson, 2000)
- **Traumatic events** (e.g. People who have experienced emotional, physical or sexual abuse during childhood, RCPsych), bullying, grief, emotional abandonment, a serious illness
- **Critical life event** which causes a big change (redundancy, failing exams, changing schools) can = distress = trigger.
- **Disrupted upbringing** (being in local authority care, parental marital problems, separation or divorce) **LAC & care-leavers** are between 4-5 times more likely to self-harm as adults (DoH, 2012)
- **Smoking** linked to self-harm (Makikyro, 2004)

#### Environmental
- **Friends**: Those who have friends that also self-harm esp girls cutting
- **Family issues** parental criminality and/or family poverty)and continuing family relationship problems
- **Isolation**: Those isolated from more ‘mainstream’ society are at higher risk; e.g. LGBT groups (RCPsych)
- **Certain cultural groups**:
  - Young South Asian females (15-35yrs) in the United Kingdom seem to have a raised risk of self harm. Intercultural stresses and consequent family conflicts may be relevant factors (Hawton, 2005)
  - Rates of self-harm were highest in young Black females (16–34 years) in 3 UK cities (Cooper, 2010)
- **New media?**

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If we can identify risk factors we can attempt universal prevention (e.g. in schools where peers may be self-harming) OR selective prevention where we target at-risk groups (e.g. CJS leavers)
Suicide: What is it?

Common:
- **SUI thoughts** - 20%- 45% of older adolescents had suicidal thoughts at some time (Hawton, 2005) this does not always = an attempt.
- But…Someone who has thought about suicide in the past, however vaguely or rarely, is more likely to resort to it as a means of coping when life becomes stressful (Samaritans).
- **SUI attempts** - at least 24,000 each year. More common among young females; peak 16 -18 yrs (Gould, 2003).
- Attempts can be impulsive (drunk, distressed, angry) or planned (premeditated)
- **SUI death** - those aged 15-24 years - suicide is the second biggest cause of death after RTAs (Samaritans). Death is more common in young males.
- Most common methods in UK is (1) hanging (2) self-poisoning (overdose) & (3) jumping from a height

Underreported:
- Figures are unclear – all will be underreported

On the rise:
- Worldwide rates of suicide are expected to rise over the next 10 years (WHO 2010b).

Preventable:
- Suicides are not inevitable: services, communities, individuals and society as a whole can help to prevent suicides

Suicide behaviours (All)
- 140,000 attempts
- 6,045 deaths by suicide

Suicide behaviours (young people)
- 24,000 attempts (aged 10-19 years)
- 1,103 deaths by suicide (aged 15-29 years)

ONS Suicide rates, 2011 in those over 15 years
## Risk factors for suicide

### Biological
(our genes, our brain structure and chemicals)

- **A family history of suicide**: Family bereaved by a suicide are at increased risk of MH problems & suicide themselves (HMGovernment, 2012). Transmission aggressive behaviour.
- **Family MH**: Children of depressed parents are more at risk of suicidal thoughts (Valenstein et al, 2012)
- **Prescription drug side effects**: some drugs, such as SSRIs, have suicidal thoughts as a side effect. This is especially true in young people.
- **Physical illness and long-term conditions**: PI is a significant risk factor for suicide independent of other factors (Qin et al, 2013) some LTC are associated with an increased risk of suicide: epilepsy, cancer, coronary heart disease and COPD = higher suicide risk (Web et al, 2012)
- **Hormonal & genetic factors**: dysfunction of hypothalamic-pituitary-adrenal axis & genes might be linked with impulsive aggression (USPHS 1999).

### Psychological
(our upbringing, how we deal with things)

- People who **self-harm** are at increased risk of suicide (although this is not intentional).
- **Personality traits**: social-perfectionism & self-criticism = higher risk (Samaritans, 2012), **Antisocial** behaviour traits , esp in women (Evans, 2004) impulsive, poor problem solving ability or coping
- **Psychiatric difficulties**: ppl with serious MH problems are about 10 times more likely to attempt suicide. E.g. bipolar disorder (10-15% die by SUI), schizophrenia (4% die by SUI) depression, ADHD or personality disorders.
- **Past attempts indicate risk**: 1/2of those who take their own life have tried before.
- **Masculinity**: suicide way of expressing or regaining control in the face of depression (Samaritans, 2012).
- **Alcohol & drugs**: 1/3 adolescents sui’s used alcohol at time (Houston,, 2001) binge drinking (Hawton et al, 2012)
- **Smoking** and nicotine dependence are associated with suicidal behr (HMGt,2012)
- **Traumatic events** (bereavement, end of a relationship, unplanned pregnancy, domestic abuse, childhood abuse or bullying) can = distress = trigger.
- **Critical life event** which causes a big change (redundancy, failing exams, changing schools) can = distress = trigger.

### Environmental
(our social lives, environment, friends)

- **Environmental risk factors for men = unemployment; family & relationship problems** - marital breakup and divorce; social isolation and low self-esteem.
- **Suicide is more common if unemployed and in lower social class bands**.
- **Those with a disrupted family background**: parents who attempted suicide, broken family relationships or violent abuse at home. Suicidal young men are more likely to have a father who is absent (Samaritans.org).
- **Those people isolated from more ‘mainstream’ society are at higher risk**: the homeless, immigrants and refugees, LGBT groups, students and prison system.
- **Exposure to others who have died by suicide** (in real life or via the media); there may be a risk of copycat suicides in a community, particularly among young people, if another young person or a high-profile celebrity dies by suicide.
- **Living apart from parents** (Evans, 2004)
- **New media?**
Life chart approaches investigating youth suicide suggest three groups

- **Psycho-social factors**
  - those with longstanding life and behavioural problems, school failure, family relationship problems, childhood sexual abuse, family violence, personality problems, low self-esteem, & poor peer relationships

- **Bio-psycho**
  - those with major psychiatric disorder (i with a protracted suicidal process ii with a brief suicidal process)

- **Stress reaction**
  - those in whom the suicidal process occurred as an acute response to life events

Impact low mood, self-harm & suicidal thoughts

Physical & mental health
- Depression = increased risk of: coronary heart disease; cancer; osteoporosis in women; & general ill-health from increasing pain and disability; (Kiecolt-Glaser et al, 2002).
- Self-harm can increase risk of intentional suicide later or of accidental suicide.
- 1 in 8 adolescents who self-harm end up in emergency care at hospital. (Hawton et al, 2012)
- Suicide; obvious outcome of death. Impact on family, peers etc.

Work and school
- Feeling upset, tired and unable to concentrate = attendance difficult = avoid work/school = affect your performance = limit your employability / money worries.
- Those experiencing suicidal thoughts are more likely to be unemployed and more depressed, and have more drinking problems (Valenstein et al, 2012).

Relationships & Friendships
- Socialise less = spiral of isolation and less opportunity for positive experiences = continuing isolation and fewer social connections.
- People with suicidal thoughts are more anxious, avoidant and inflexible, have weaker social networks and less solid families (Valenstein et al, 2012).

These problems can (1) persist into adulthood (2) be costly to the individual, their family and society.

Need to prevent these outcomes at all costs = early intervention.
What help is out there?

Recommended treatment

• Suicide attempt / Self-harm, immediate:
  • Acute A&E, minor injuries etc

• Longer-term support:
  • Look at the cause of distress / increase coping techniques: psychotherapies, psychology, support.
  • Role of medication - lithium and clozapine may have specific anti-suicidal properties, (Cipriani et al., 2005; Meltzer et al., 2003) but certain antidepressants (SSRIs) may be associated with increase in suicidal behaviour esp in young people (Barbui et al., 2009; Fergusson et al., 2005).

• Family support after a suicide
  • Survivors of Bereavement by Suicide (SoBS) for those affected by suicide of a loved one. Helpline: 0870 241 3337 Website: www.sobs.admin.care4free.net

Young people are often afraid to ask for help: fear of stigma, diagnosis & confidentiality

It is a myth that those who talk about it won’t do it…most people will have mentioned something to someone

Hannah Smith suicide: Teenager used Ask.fm in secret after being banned from going on it by worried father

Hannah kept her use of the site a secret from her big sister, setting up another Facebook account which she used as another way of accessing Ask.fm

‘I wanted out’: Prison Break’s Wentworth Miller reveals how hiding his sexuality led to multiple suicide attempts... starting at just 15

By DAILY MAIL REPORTER
PUBLISHED 00:46, 9 September 2013 | UPDATED 15:20, 9 September 2013

Wentworth Miller has revealed he tried to commit suicide at 15-years-old as he struggled to keep his homosexuality a secret.

The 41-year-old actor made the shocking revelations during a speech at the Human Rights Campaign Dinner in Seattle on Saturday night.

He added that his first attempt to kill himself was “the first time” among multiple occasions.

‘Every day was a test and there was a 1000 ways to fail”, the Prison Break actor told the hushed audience in a video obtained by TMZ.

“A 1000 ways to betray yourself” not to come up to someone else’s standard as to what was acceptable and what was normal.

And when you fail the test, which was guaranteed, there was a price to pay: Emotional, psychological, physical. And like many of you I...
Interventions for preventing suicide & self-harm

**Universal prevention;** targeted at the general population.
Improving the mental health of the general population is one way to reduce suicide & DSH.

- Reducing access to the means of suicide ⇒ ligature points in PICUs, safer prescribing, cell safety, local building planning or suicide pits on the underground.
- Schools highlighting problems such as cyber bullying, body image and self-esteem ⇒ build resilience ⇒ contribute to suicide prevention among children and young people.

**Selective prevention;** preventing/reducing development of problems in those **at risk.**
At-risk: MH, care leavers, those in the CJS, survivors of abuse, BME groups, drug users.

- Ensuring that front-line staff working with high-risk groups receive training in the recognition, assessment and management of suicide risk ⇒ early detection.
- Funding community groups that support BME groups ⇒ better access to healthcare.

**Indicated prevention;** preventing/reducing transition to serious health problems in ppl already experiencing low level symptoms (**distress, self-harm, suicidal thoughts**)

- Improving referral pathways from A&E and primary care for those who are self-harming.
- Vigilance by statutory and local agencies working with people with distress and associated problems such as debt, domestic violence or unemployment.
Interventions for preventing suicide & self-harm

**Population measures**
- School-based psychological well-being and skills training programmes
- Gatekeeper training (school teachers, peers)
- Screening to identify those who might be at risk
- Restriction of access to means used for self-harm and suicide
- Improved media reporting and portrayal of suicidal behaviour
- Encouragement of help-seeking behaviour
- Public awareness campaigns
- Help-lines
- Internet sources of help
- Reduction of stigma associated with mental health problems and help seeking

**Measures for at-risk populations**
- Psychosocial interventions for adolescents at risk of self-harm or suicide (depressed, CJS, LAC)
- Screening of those at risk (e.g. young offenders)
- Psychosocial interventions for adolescents who have self-harmed
- Pharmacotherapeutic interventions for adolescents at risk of self-harm or suicide
- Improving care pathways in healthcare such as A&E
# Interventions for self-harm

A Cochrane review of 23 RCTs which reported outcomes of repetition of deliberate self-harm (non-fatal)

*Only two focused on adolescents (Cotgrove 1995; Harrington, 1998)*

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<thead>
<tr>
<th>Cochrane Review</th>
<th>Intervention</th>
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<tr>
<td><strong>Dialectical behaviour therapy vs. Standard</strong></td>
<td>Flupenthixol vs. Placebo</td>
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<td>1 study (Linehan 1991)</td>
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<td>Significantly lower rate of self-harm during the follow-up period</td>
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<td><strong>Intensive intervention and Outreach VS usual care</strong></td>
<td>Antidpressants vs. Placebo</td>
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<td>Reported no consistent effect</td>
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<td><strong>Emergency crisis card vs Standard care</strong></td>
<td>Home-based family therapy vs. standard after-care</td>
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<td>2 studies (Morgan 1993; Cotgrove 1995)</td>
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<td>Showed a trend towards less repetition of self-harm but this was not significant.</td>
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<tr>
<td><strong>Problem solving vs. usual care</strong></td>
<td>Other study designs</td>
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<td>5 studies (Gibbons 1978; Hawton 1987; Salkovskis 1990; McLeavey 1994; Evans 1999)</td>
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<td>reported reduced repetition of self-harm in problem solving therapy but the change was not statistically significant</td>
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<td><strong>Long-term therapy vs. Short-term therapy</strong></td>
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<td>1 study (Torhorst 1988)</td>
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<td>No difference in terms of preventing repetition of DSH in Long or Short term therapy</td>
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<td>Helped a sub-group of female patients with borderline personality disorder and recurrent self-harm</td>
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<tr>
<td><strong>Antidpressants vs. Placebo</strong></td>
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<td>1 trial (Montgomery 1979)</td>
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<td>significant reduction in repetition of DSH with flupenthixol</td>
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<td><strong>Home-based family therapy vs. standard after-care</strong></td>
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<td>1 study (Harrington 1998)</td>
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<td>No beneficial effect of family therapy carried out in the patient’s home on DSH</td>
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<td>But: non-depressed patients in family therapy showed a greater reduction in suicidal ideation at follow-up</td>
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<td><strong>Other study designs</strong></td>
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<td></td>
<td>Inpatient behaviour therapy vs. Inpatient in-Sight-orientated therapy (1 study)</td>
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<td>Same therapist vs. Different therapist (1 study)</td>
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<td>General hospital admission vs. Discharge (1 study)</td>
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<td>All small sample size, skewed groups</td>
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Interventions for suicide prevention

- 3 main settings. Goals are mainly: (1) find people and refer them (2) reduce risk factors

**School**
- Skills-based programmes = enhance protective factors (problem-solving, coping) & target risk factors (depression, drug use).
- **Some promising findings** (Gould, 2003).
- Gatekeeper training = peers & adults recognise suicide warning signs.
- **Some evidence** = improves knowledge, attitudes, increase help-seeking, & reduces DSH short term (Aseltine et al, 2007)

**Community**
- Crisis centres / phone lines
- Reducing the means e.g. weapons legislation, tablet restrictions
- Media guidelines – prevent copycat suicides
- **NO solid evidence** that any of these reduce suicide rates in their areas.

**Healthcare**
- Training primary care workers to identify at-risk young people (many young people seek help in preceding month)

**Some evidence** that training = increased identification of suicidal patients (Gould 2003). And that physician education in depression recognition, treatment and restricting access to lethal methods reduces suicide rates (Mann, 2005)

Interventions for suicide prevention

• A systematic review of suicide & self-harm interventions (De Silva et. al., 2013, Australia).
  - Included 6 systematic reviews and 38 controlled studies which were mostly psychological interventions
  - Showed some evidence that interventions could be effective, such as school-based prevention programs with a skills training component, individual CBT interventions, interpersonal psychotherapy, and attachment-based family therapy.

• A review of schools-based interventions (Robinson et. al., 2013, Australia)
  - Review of 43 studies (15 awareness programs, 23 selective interventions, 3 targeted interventions, and 2 postvention trials.)
  - The most promising interventions for schools appear to be gatekeeper training and screening programs. However, limited evidence on effectiveness.

• School-based suicide-prevention programs (Katz et. al., 2013 Canada).
  - Reviewed 16 published intervention studies
  - Most focused on knowledge and attitudes toward suicide
  - 2 had significantly reduced subsequent suicide attempts
  - Several others impacted on suicidal ideation and improved general life skills and gatekeeper behaviour
What works?

Self-harm

- The evidence-base on interventions for self-harm isn’t very conclusive (Hawton et al, 2009)
- but some interventions based on CBT or ‘problem-solving therapy’, which teach new methods of coping and offer brief but swift response to crisis, will prove helpful.
- pharmacological interventions for this age group are generally discouraged.
- also ensuring young people know where to go for quick access to help is very important

Suicide

- The evidence-base on interventions for suicide is limited
- Some evidence of effectiveness in school-based prevention programs with a skills training component gatekeeper training and screening programs OR in individual CBT, interpersonal psychotherapy, and attachment-based family therapy.

Conclusion

- Need more research with young people, sufficient numbers and in the UK. Especially into: better prediction suicide in young people; understand role of self-harm; understand different levels of self harm, & understand impact of new media
- More school-based approaches targeting adolescent self-harm are needed
- Develop and assess new interventions that are acceptable to young people in the UK
- Need for multi-agency working (education, social care, health service) for early identification and help
- Develop interventions that reduce stigma regarding help-seeking
- Improve access to treatment, improve transitions between services
Sources of help

LOCAL CONTACTS

Your GP to find your local GP on NHSchoices website

- A&E is open 24/7 at your local hospital and can be accessed by anyone feeling suicidal for help, they will probably ask you to speak to the psychiatric liaison nurse. Birmingham A&E includes: Accident and Emergency Departments at Heartlands, Solihull, City, Selly Oak and Good Hope Hospitals.

- BSMHFT Youth services. See www.bsmhft.nhs.uk/our-services or Tel: 0121 3011850

- SASH (Support and Action on Self Harm) Run at the Zinnia hospital sash@bsmhft.nhs.uk or tel 0121 301 5370.

- Birmingham Mind / Solihull Mind. Mind is a mental health charity who works to create a better life for everyone with experience of mental distress Tel: 0121 608 8001 / 0121 742 4941 or go to www.birminghammind.org

NATIONAL CONTACTS

- C.A.L.M. is the Campaign Against Living Miserably. Raising awareness regarding feelings of misery and the high suicide rate of men aged 15–35 years. Being silent isn't being strong! CALM Helpline on Tel: 0800 58 58 58 www.thecalmzone.net

- Childline the UK’s free, confidential helpline dedicated to children and young people. Tel: 0800 1111 Web: www.childline.org.uk

- National Self Harm Network Offers information about self-harm, plus an online support forum www.nshn.co.uk

- Papyrus provides UK resources and support for those dealing with suicide, depression or emotional distress – particularly teenagers and young adults Tel: 08000 68 41 41 or www.papyrus-uk.org

- Recovery Our Life a site for people who self harm www.recoveryourlife.com

- Samaritans runs a helpline and website providing confidential emotional support for people who are experiencing feelings of distress or despair, including those which can lead to suicide. Helpline (24 hours): 08457 90 90 90 Website: www.samaritans.org.uk or e-mail: jo@samaritans.org

- Survivors of Bereavement by Suicide (SoBS) Self-help organisation for those affected by suicide of a loved one. Helpline: 0870 241 3337 (9am - 9pm daily) Website: www.sobs.admin.care4free.net

- Self Injury Support Offers information about self-harm, including some leaflets in Bengali, Chinese, Punjabi and Urdu. They operate a text service where they respond to all texts, Text on 0780 047 2908 or email TESS see more at: http://www.selfinjursupport.org.uk/
Sources of information

30th September
Suicide Awareness Film Screening
Trinity Theatre @ 19.30

Wellbeing projects and bbc launch youth suicide awareness film

Suicidal Thoughts

What are suicidal thoughts?

Most young people think about death to a certain extent but when emotional pain, feelings of hopelessness or not knowing how to cope, become too much, this may lead to suicidal thoughts.

Suicide is the act of a person consciously choosing to end their own life. Suicidal thoughts can range from thoughts of being better off dead, wishing you weren't there anymore, to thinking how you might kill yourself or planning when and where to kill yourself.

People who feel this way do not necessarily want to die, they may just be unable to see any other way of coping with life as it is and simply want to cease to exist.

www.youthspace.me/selfharm
and
www.youthspace.me/suicidalthoughts
References

- The National CAMHS Support Service produced a self-harm in children and young people handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children’s services can respond. www.chimat.org.uk/resource/view.aspx?RID=105602