Suicide and Self Harm

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Children and Young People's Mental Health: Right Care-Right Time

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Time only permits a brief discussion today. Please read the following articles: **Suicide and self-harm: vulnerable children and young people**, published in *Practice Nursing* (2019) Vol.30 No. 5 (which will be made available to you as well as a larger PP with all references from this PP and links to resources FYI)

Review of: Suicide and self-harm prevention Skills for Schools by MindEd 2019, for *Child Abuse Review* 23.08.2020, available from: https://onlinelibrary.wiley.com/doi/10.1002/car.2628

In addition to my articles there are some newer statistics re suicides, please see: *The BMJ*: Suicide rates continue to rise in England and Wales: https://www.bmj.com/content/370/bmj.m3431 (it includes September 2019 stats and links to other articles re the current pandemic)

‘Suicide and Me’ is a documentary by ‘Professor Green’ (aka Stephen Manderson) and worth watching, you will see the sad generational aspects of death, loss, stigma and suicide in families: https://www.youtube.com/watch?v=oZC53wKqjNE

November 2021: British Journal of Psychiatry, Offspring's risk for suicidal behaviour in relation to parental death by suicide: systematic review and meta-analysis and a model for familial transmission of suicide, available from:

https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/abs/offsprings-risk-for-suicidal-behaviour-in-relation-to-parental-death-by-suicide-systematic-review-and-metaanalysis-and-a-model-for-familial-transmission-of-suicide/C450526CAF5F329AF48E656660DEB6A7

Key points from my article

Suicide is the leading cause of death among 15–35-year-olds in both men and women and is a major public health concern; it occurs at a higher rate in this population than any other age group (Edwards, 2018). Globally 700,000 annually (WHO 2021)

It is estimated that only one in eight children and young people attend hospital following a self-harm episode, usually from an overdose in the community (Hawton et al, 2012).

An estimated two hundred children a year lose their lives through completed suicide in the UK (Papyrus, 2022). These figures are likely to be an under-estimation as coroners' verdicts can be inconclusive unless there was clear evidence of the intention to take one's life (such as a suicide note).

Historical aspects are Important to consider, they have influenced 'today'

Suicide was a criminal act until 1961, hence the continued use of the terminology 'committed' suicide; however, the term 'completed' is more appropriate and should be promoted and used universally (about reframing language).

1852 article in local paper described a male attempting "self destruction" by hanging. Taken before the magistrate and imprisoned for 1 week for his wickedness!

1908 article, young woman of 23 charged in city police court for attempting to cut her throat. Despite acknowledging her depression, she was fined £10! (Grundy 2008)

Discussion

How do you think historical views around suicide may influence current situations and the experiences young people have in clinical and Primary Care settings, and the wider context?

Young people often have negative experiences when arriving at A and E

Suicidal feelings and self harm

Young people are vulnerable to suicidal feelings and self-harm is a sign of serious emotional distress (Department of Health, 2011; Royal College of Psychiatrists, 2020).

The risk is greater when they have any of the factors shown in the following slide, which can often combine into complex experiences and events for a young person

Factors influencing self harm and suicide

Behavioural disorders ● Substance misuse ● Family breakdown ● Rejection ● Mental health problems ● Suicide in the family or a friend ● Academic pressures ● Bullying ● Bereavement ● Substance misuse ● Childhood abuse ● Sexual abuse

Adverse Childhood Experiences (ACES) (next slides 9-13)

The 10 ACEs in the 1990's Kaiser study (17,000 participants):

Five are personal:

Physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect.

Five are related to other family members:

A parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment.

Today we could consider many other traumas such as bullying, racism, homelessness, surviving an accident or disaster, to name a few. At the time of the study these were the traumas identified as common to them

The study found a strong link between trauma and chronic disease in adulthood as well as social and emotional problems as shown in the Resilience film trailer: https://www.filmsforaction.org/watch/resilience-the-biology-of-stress-and-the-science-of-hope/ (2.10 mins)

Nadine Burke Harris TED talk (16.02 mins) *How childhood trauma affects health across a lifetime,* available from: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

You can work out your own ACE score here: https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf

Young Minds have an excellent resource you can download; Addressing Adversity: https://youngminds.org.uk/resources/policy/addressing-adversity-book/

(all accessed April 2021)

Adverse Childhood Experiences are associated with an increased risk of suicide (Cleare et al 2018)

Yet despite experiencing ACEs not all children will have a poor outcome

But children experiencing 4 or more ACEs are 4 times more likely to have low levels of mental wellbeing

We can also consider this in the context of 'risk and resilience'

It is essential we understand 'at risk' groups and the importance of 'resilience' and its role in mitigating risk

There is now an increased dialogue on trauma and the effect of trauma on development with life long consequences

Move to areas and schools being 'trauma informed', see: https://traumainformedschools.co.uk/ (accessed June 2022)

Helpful for those working in universal settings with children and young people have an interest in attachment and child and adolescent mental health, to be able to interpret what is being communicated through children's behaviour in the setting or classroom and know how to help

Important to understand ‘behaviour’ what is driving/being communicated by ‘behaviour’ and what is the context?

Hearing the story

Think ‘systemically’; what do we mean?

About being curious, compassionate and caring

Requires resources, investment and understanding

Being ‘trauma informed’ helps

Psychological distress not necessarily indicative of a mental health problem; very important consideration

Could be a ‘normal reaction’ to overwhelming stressors and trauma fueling anxiety; reminder these are extrinsic factors and nurture trumps nature…

Having a supportive relationship with an identified person is key

There is often an urge for diagnosis

Need for recognition and appropriate help

Re-programming of language can be helpful

Not: What’s wrong with you? Instead: What has happened to you?

Often, one of the first indicators of emotional distress can be self-harm. There is can be a minimising of the significance of self-harming behaviour among professionals and others; commonly describing it as ‘attention-seeking’. It must be remembered that this is a young person in psychological and emotional distress

Self-harm is often the opposite of seeking attention; the behaviours can be secretive and people suffering with self-harm often attempt to conceal it.

A more appropriate way of reframing the language of ‘attention-seeking’ is instead to use the terms ‘attachment-seeking’ or ‘attachment-needing’.

Self harm and suicidal behaviour

Self-harm and suicidal behaviour are emotional disorders on a similar continuum as they are both in response to stress.

A young person engaging in suicidal behaviour may have a wish to die or be ambivalent about their life/future, whereas young people engaging in self-harming behaviour do not necessarily have an active wish to die (see next slide)

Self-harm tends to be about coping, whereas suicide is more concerned with ‘giving up’ as a solution to overwhelming stressors (Burton, Pavord and Williams, 2014) As a coping mechanism, self-harm can be difficult to stop without an alternative management strategy.

Definition of suicide

The consideration of or desire to end one’s life ● Ranges from passively wanting to die to active ideation ● Suicidal thoughts may occur as frequently as once per week ● Suicide attempt differs from ideation with an attempt there is an action intended to end one’s life ● Suicide death defined as a fatal action to deliberately end one’s life

Key considerations

Key considerations when consulting or communicating with patients/young people about self-harm and suicide are intent and motivation.

For example, high intent and motivation in the case of overdosing could include collecting and hoarding several tablets over time and not telling anyone following the overdose or self-harm attempt. It is important to know what a young person thought would happen following their attempt, and the same can be true for taking a relatively low number of tablets if one thought it would have the same fatal effect. Therefore, individual assessment is highly important

Behaviours

Self-harm behaviours include poisoning, cutting, excessive alcohol, illegal drugs, hitting or burning oneself (Royal College of Psychiatrists, 2020).

Other signs of self-harm include unexplained injuries, covering up the body (perhaps inappropriately for the season), and an unwillingness to participate in sports where less clothing is required. All these activities have the potential to proceed from self-harm to suicidal behaviour or ideation, depending on the individual and, for example, when cutting or excessive alcohol use become significantly escalated with enough lethality to be classed as a suicide attempt

Having a self-harm history can predispose a young person to eventual suicide completion (Hawton et al, 2011). More than half of people completing suicide had a self-harm history (NHS, 2018).

Some children and young people may have both physical illness and mental health problems combined. For example, a young person with diabetes may place themselves at risk through non-compliance with treatment and be at risk of serious complications.

Links with the developmental process

Suicide and suicidal ideation are invariably and almost always linked to relationships and relationship difficulties, which is a challenge to explore and understand

It is also where hope lies in our supportive relationships with young people

There are always emotional and psychological components.

Studies of suicidal behaviour in young people confirm that relationship difficulties predominate (Hawton et al, 2012).

Exceptions include those responding to delusions or hallucinations linked to drug misuse or psychosis

Many children and young people who experience negative problems during this crucial and critical period, when their brains are still forming, may have an impaired attachment quality, which then tends to be borne out in all future relationships and affects the capacity for emotional and self-regulation (Howe, 2011).

Physical Pain-a medium of communication

During human development, infantile experiences are internalised and attachment patterns are laid down, affecting later relationships, and events that trigger self-harming behaviour are rooted in these old patterns

Although experiences are not necessarily traumatic (not all who self-harm have been victims of abuse or trauma in childhood), the skin becomes a medium for communication (Gardner, 2001).

High numbers of suicide attempts during the adolescent period has been linked to the developmental process. Adolescence is a turbulent period with considerable challenges in biological, psychological and social change; risk-taking activity is also part of normal adolescent pathology. This can lead to vulnerability to developing psychosocial disorders, which peak during adolescence, such as suicide, self-harm, substance misuse, offending behaviour, depression and eating disorders (Anderson, 2008).

Often the shocking nature of self-harm communicates the rawness of the emotions and impulses in the individual (Turp, 2001). Physical pain is often easier to manage than emotional pain, and when inflicted, it can change the individual's mood and consequently habits are formed. Cutting releases endorphins, providing a brief calming effect, and when combined with serotonin, a mood enhancer, the experience is one of temporary relief (Howard, Burton and Levermore, 2020). It is important to recognise first aid, 'patching up' and 'repairing' either by the individual or helpers, and these repairing acts can be experienced as therapeutic.

Triggers for self harm and suicide

There are several risk factors that predispose a young person to self-harm and suicidal behaviour, yet many individuals will tick several of those boxes. What is important to understand is that triggers are often what precipitate, and are the reason behind, an act of self-harm. These include both individual and context-specific aspects and can be seen on the next slide. For example, bullying and the role of social media are being more frequently cited as a reason. The death of Molly Russell, aged 14, is an example of social media being identified as a cause (BBC News, 2019).

Trigger factors for self harm

Individual triggers: ● Bullying ● Difficulties with parental and peer relationships ● Bereavement ● Earlier abusive experiences ● Difficulties with sexuality ● Problems with ethnicity, culture, religion ● Low self-esteem ● Feeling rejected Contextual triggers: ● Adverse family circumstances ● Dysfunctional relationships and domestic violence ● Poverty ● Parental criminality ● Time in local authority care ● Frequent punishments ● Family transitions ● Compounded by physical/emotional changes of adolescence

Triggers become symbolic of conflict in relation to independence/dependence and ensuing guilt

Caretaking aspects of the adolescent are split off; there has been no taking over where the parent's have left off

Suicide attempts provide an active response to these stressors

Often seen as a *solution* to intolerable, overwhelming feelings rather than a wish to die

Often about a last remaining sense of power

Understanding how a young person manages stress is crucial. Current presentations typically symbolic of earlier childhood difficulties and are evidence of early experiences of inter-personal familial and relationship difficulties (Briggs 2002)

Immediate factors about relationships contribute to our understanding (Wohl 1995)

Royal College of Psychiatrists (2010) warned against a culture of solely assessing risk. In so doing it would lead to an exclusion of thinking about psychological considerations in both the future prevention and treatment of survivors

Physical pain can often be easier to manage than emotional pain

Inflicting pain can change mood which can be habit forming

Cutting releases endorphins into the system providing a brief calming effect and seratonin, enhancing mood

Seen as a form of relief

Without a thorough psycho-social assessment one cannot conclude upon what an intended outcome might have been

A young person engaging in suicidal behaviour may wish to die or be ambivalent

A young person engaged in cutting may not have an active wish to die

Therapeutic Task

The therapeutic task is to re-invoke, re-join split off aspects of self preservation

Workers take on a variety of roles including rescuing, caring, interpreting. When experiences become thought about movement takes place from unconscious to conscious (Gardner 2001)

What happens following admission to A and E?

Once a young person is medically fit for discharge, they will be seen by a member of the CAMHS team, within 48 hours, who will conduct a full psycho-social assessment which will also include consultation with parent/carer/other agencies, and a risk assessment

Decision about safety to return home agreed upon

Typically, they would be followed up in clinic a week later

Important to link assessment and treatment, but does this happen in practice?

According to local and national policy (NICE 2013)

(there has been a recent NICE update re self harm guidance)

There is universal misunderstanding about self-harm by the people closest to them, leading to poor responses (Mental Health Foundation 2006)

Self-harm stigmatised, remaining hidden leading to guilt and shame often compounded by reactions of others (NSPCC 2009)

The notion of a *trigger* as an explanation, often leads to minimising the level of seriousness surrounding a suicide attempt, which is *never* about the stated reason

Importance of attitude

"Long term relationships with workers rather than offers of time limited work provide continuity and the chance to build rapport. I want workers to be more concerned about me, genuinely, than only to be thinking about risks"

(Truth Hurts 2006 p.69)

Interesting research (Stewart 2018) re attitudes..

Three themes:

- Attitudes towards the young person
- Practical aspects of help
- Need for parents to be involved

Attitudes towards the young person

Range from helpful caring approaches to judgemental approaches

Less positive attitudes if self harm had occurred more than once

The experience of assessment felt like an interrogation or tick box exercise

Young person not taken seriously

Described how important building a relationship between young person and clinician was

Main treatments offered

CBT

DBT

Seen as offering young person practical tools to manage

Key POINTS

Self-harming behaviour is often negatively referred to as ‘attention-seeking’; however, self-harm is indicative of emotional distress and should be termed as ‘attachment-seeking’ or ‘attachment-needing’ ● Self-harm and suicide always have a relationship component ● Reframing of language from ‘committed suicide’ to ‘completed suicide’ is important as it is no longer a criminal offence ● Looked after children and young people have an increased risk of self-harm and suicide and are therefore highly vulnerable ● Risk factors predispose a young person to self-harm and suicidal behaviour; triggers precipitate an act of self-harm or suicidal behaviour ● Increased mental health service thresholds and waiting times mean practitioners can be left in a holding capacity ● Access and good relationships with local mental health service provision and to individual supervision is essential

NHS Digital (2018) prevalence data:

NHS Digital (2018) announced that one in eight (12.8%) of children and young people aged between five and 19, surveyed in England in 2017, had a mental disorder. This is an increase from one in ten (10%) in the last published research in 2004

Available from: NHS Digital (2018) https://digital.nhs.uk/news-and-events/latest-news/one-in-eight-of-five-to-19-year-olds-had-a-mental-disorder-in-2017-major-new-survey-finds (accessed April 2021)

NHS Digital (2020) prevalence data:

Estimates since the first Covid 19 lockdown are now 1 in 6 (16.0%)

Noted that **(62.6%) children aged 5 to 16 years with a probable mental disorder had regular support from their school or college**

Available from: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up (accessed April 2021)

Consider:

Self-harm-coping?

Suicide-giving up?

Opposing outcomes?

Similar continuum as both a stress response

Evidenced that skilled support at a first episode of self-harm offers an opportunity to prevent further self-harm and a completed suicide

NSPCC 2009 cited in Supporting Children and Young People who self harm; available from: http://rotherhamscb.proceduresonline.com/pdfs/self_harm.pdf (accessed March 2021)

Finally

Why is it important to be aware of the differences and connections between self-harm and suicidal behaviour?

How important is it to understand the young person's context and to hear their story?

What is the importance of vigilance and a therapeutic approach when concerned about a young person who may be self-harming?

Remind ourselves:

Children and young people's health requires attention and understanding including an appropriate response as urgently as any other health crisis

Needs to be understood within a context of past and current experiences

The role of trauma and its effect on psychological well-being and outcomes

Let's be 'trauma informed'

Remember the ACEs

Take your own score

Let's reframe our language; not: What's wrong with you? Instead: What has happened to you? Being curious……

Work on improving resilience

About being curious, compassionate and caring

We must consider our own self care and ensure access to supervision

Useful links/other info:

Cross-Government Suicide Prevention Workplan (2019)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-prevention-strategy-workplan.pdf (accessed March 2021)

Trends in suicide during the Covid 19 pandemic

- BMJ November 2020 article: https://www.bmj.com/content/371/bmj.m4352
- (accessed March 2021)
- Radio 4 File on 4 26th February 2021 'Surviving Self-Harm' is up to date and worth listening to: https://www.bbc.co.uk/programmes/m000s9vx (accessed March 2021)
- This article featured in The Guardian (16.02.2021) relates to the above R4 broadcast: Self-harm among young children in UK doubles in six years https://www.theguardian.com/society/2021/feb/16/self-harm-among-young-children-in-uk-doubles-in-six-years?CMP=Share_iOSApp_Other
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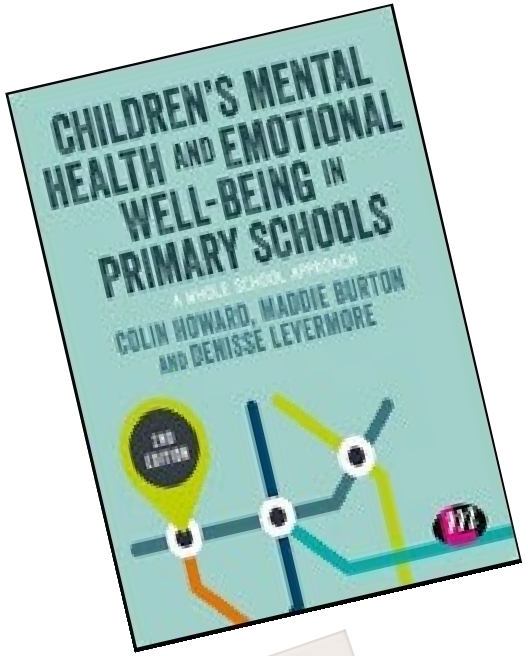
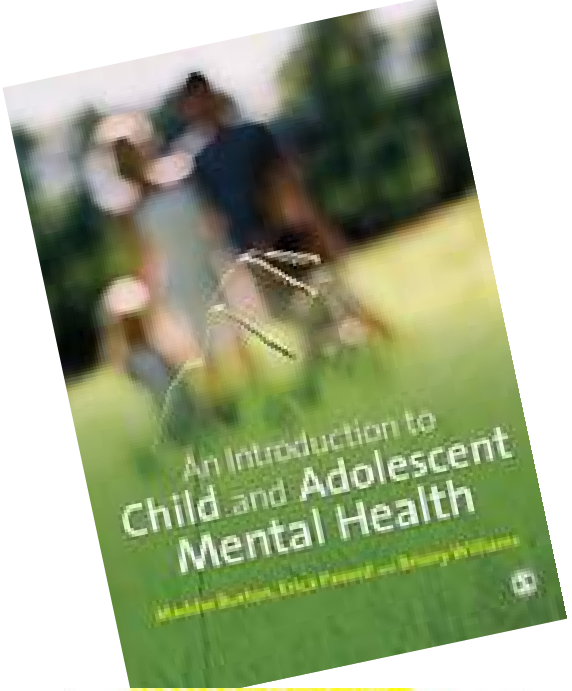
MindEd

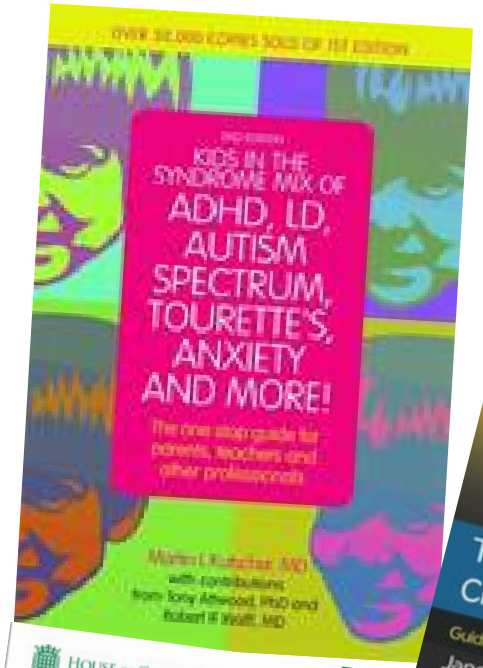
e-learning to support young healthy minds

A pioneering website providing free online education to help adults identify and understand children and young people with mental health issues

www.minded.org.uk







Future In Mind

THANK YOU!

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