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**The British
Psychological Society**
Promoting excellence in psychology

British Psychological Society response to the National Assembly for Wales Health Committee

Suicide Prevention

About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for NAW to contact us in the future in relation to this inquiry.

Please direct all queries to:-

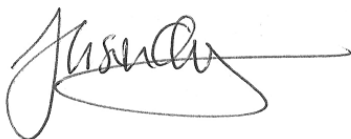
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About this Response

The response was jointly led on behalf of the Society by:

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We hope you find our comments useful.



Alison Clarke
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Dr Paul Hutchings CPsychol AFBPsS
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Suicide Prevention

	<p>The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.</p>
<p>1.</p>	<p>Comments:</p> <p>Numbers of People Dying / Trends and Patterns Statistical data on the number of people dying by suicide is found in the Office of National Statistics, Suicides in Great Britain: 2016 registrations. For example,</p> <p>‘The rate in Wales has fallen from 13.0 in 2015 to 11.8 per 100,000 people in 2016. The suicide rate in Wales is generally more erratic than in England, due mainly to having a smaller population, making any long- and short-term trends difficult to identify. Welsh males saw their lowest rate in 2008 at 15.1 and their highest in 2013 at 24.3 suicides per 100,000 males. Similarly to females in England, a large improvement was seen during the 1980s but there has been little change since’. (ONS, 2016 registrations).</p> <p>Vulnerable groups Bruffaerts et al. (2011) found that roughly 60% of people with suicidal thoughts and behaviour do not receive treatment. For those who do, there are very few evidence-based treatments (such as prevention programmes, pharmacological interventions and psychological treatments) that are available. Thus it is important that there are tailored services to target specific groups, including: men, pregnant women and new mothers, people in the criminal justice system, children and young people, LGBT, people leaving the care of mental health services, and people who self-harm. Another challenge is that despite 75% of the world’s suicides occurring in low and middle income countries (Vijayakumar & Phillips, 2016), the vast majority of research and evidence is gathered in high income countries.</p> <p>Self-harm Some recent encouraging evidence suggests that a very brief intervention based on implementation intentions (a volitional help sheet) may reduce repeated self-harm in patients admitted to hospital via emergency departments) (O’Connor et al 2017), however this was only helpful for those with a history of repeated self-harm. Results suggested that the help sheet might actually increase self-harm in those who had not previously been hospitalised for self-harm (i.e., it was their first ever hospital-treated episode), though this increase was not statistically significant. These findings now require replication.</p> <p>The Psychological Risk and Protective Factors In addition to the established role of psychiatric disorders/mental health conditions in suicide risk (Turecki & Brent, 2015; Hawton, Saunders & O’Connor, 2012), personality and individual differences, cognitive factors, social factors and negative life events are</p>

all associated with suicide risk. The key psychological risk/protective factors for suicidal ideation and suicidal behaviour are indicated in the table below and the evidence for these factors is summarised in O'Connor & Nock, 2014.

Psychological Risk and Protective Factors for Suicidal ideation and Behaviour

Personality and Individual Differences

Hopelessness
Impulsivity
Perfectionism
Neuroticism and extroversion
Optimism
Resilience

Cognitive factors

Cognitive rigidity
Rumination
Thought suppression
Autobiographical memory biases
Belongingness and burdensomeness
Fearlessness about injury and death
Pain insensitivity
Problem solving and coping
Agitation
Implicit associations
Attentional biases
Future thinking
Goal adjustment
Reasons for living
Defeat and entrapment

Social factors

Social transmission
Modelling
Contagion
Assortative homophily
Exposure to deaths by suicide of others
Social Insolation

Negative life events

Childhood adversities
Traumatic life events during adulthood
Physical illness
Other interpersonal stressors
Psychophysiological stress response

Adapted from O'Connor & Nock (2014)

In recent decades a number of theoretical models have been developed to describe the pathways to suicide (Joiner, 2005; Johnson et al., 2008; O'Connor, 2011; Klonsky & May, 2014). A commonality across most of these models is that they are grounded within the ideation to action framework (Klonsky, 2014), namely that the factors leading to suicidal thinking are distinct from those that govern the transition from thinking about suicide to attempting suicide (O'Connor, 2011; O'Connor & Nock, 2014). One of these models, *the integrated motivational-volitional (IMV) model of suicidal behaviour* (IMV; O'Connor, 2011), maps the final common pathway to suicidal behaviour. In brief, the IMV model suggests that suicidal ideation emerges from feelings of defeat or humiliation from where there is no escape (O'Connor, 2011; O'Connor et al., 2013). Whether someone acts on their thoughts of suicide is governed by a range of factors, labelled *volitional moderators* (e.g., impulsivity, exposure to suicide, acquired capability, planning, access to the means of suicide), the presence of which increases the likelihood that suicide attempts/death by suicide will occur. For example, if someone has thoughts of suicide and is impulsive or knows someone close to them who has died by suicide, they are more likely to act on their thoughts of suicide. Theories such as the IMV model are important not only to advance our understanding of suicide risk but also because they form the basis for intervention development. However, the complexity of suicide risk should not be under-estimated.

	<p>The complexity of suicide risk</p> <p>Biopsychosocial models attempt to integrate the understanding of biological, psychological and sociocultural factors associated with an increased risk of suicidal behaviour and death by suicide. They recognise that these behaviours cannot be understood from any one perspective alone. Instead suicidality is best explained as a complex interplay between risk factors across domains. As an illustration, consider the association between unemployment and suicide. Exposure to high rates of unemployment can affect an individual’s feelings of hopelessness or entrapment – to increase risk of suicidality. However, not everyone who is unemployed will feel suicidal. Risk factors are likely to interact with one another in complex ways to determine vulnerability. It is valuable to consider the contribution of biological, psychological and social factors at every point in the suicidal process. Psychological processes can be described as the biological and social factors which act to increase the risk that a person will end their life. However, even at this point, environmental factors such as the availability of means of suicide, and psychological factors, such as an individual’s propensity to select between these means, will influence the likelihood of death. Thus understanding the complex interplay between the various biological, psychological and social risk factors that contribute to risk of suicidality is critical to the development of comprehensive and effective suicide prevention and treatment approaches.</p> <p>Risk assessment</p> <p>Although risk factors that increase the propensity to engage in suicidal behaviour have been identified, suicide remains a rare event and most risk factors have little positive predictive value in determining likelihood of eventual death by suicide (Turecki & Brent, 2015; Hawton, Saunders & O’Connor, 2012; Franklin et al., 2017). Likewise, as reviewed by Bolton, Gunnell & Turecki (2015) although a number of risk assessment scales for suicide exist none to date provide enough robust evidence to justify their routine use in clinical settings and the vast majority are limited by their reliance on patient self-report (Quinlivan et al., 2017; Chan et al., 2016). Novel, evidence based, methods of suicide risk assessment are being developed, but these are still at an early stage. The National Institute for Health and Care Excellence supports the importance of conducting an assessment of patient risk and needs, but does not support the use of specific risk assessment tools (https://www.nice.org.uk/donotdo/do-not-use-risk-assessment-tools-and-scales-to-predict-future-suicide-or-repetition-of-selfharm). All individuals who present to hospital following self-harm should receive a caring assessment, which takes into account individual, social, and behavioural influences. Such an assessment should address an individual’s clinical history and current condition, their previous suicidal behaviour as well as their current suicidal thoughts and plans. It should also address their social context, help them to keep themselves safe when in crisis and support them in obtaining ongoing clinical treatment, as required. A compassionate psychosocial assessment plays an important role in establishing a positive therapeutic relationship between a clinician and patient in distress. It is important to ask about suicide in a direct but sensitive manner. Although clinicians can be concerned about exploring suicidal thoughts, there is no evidence to suggest that talking about suicidal thoughts and plans increases risk of suicidal ideation or self-harm, and some evidence that it is beneficial for those at higher risk (Dazzi et al., 2014).</p>
	<p>The social and economic impact of suicide.</p>
<p>2.</p>	<p>Comments:</p>

Postvention: Providing support after suicide

There has been increased recognition of the importance of supporting vulnerable populations, such as bereaved families and friends, following suicides (WHO, 2014). The research demonstrates that people who are exposed to suicide deaths are at increased risk of complicated grief, traumatic grief and PTSD (Melhelm et al., 2004). Furthermore, the relatives and friends of the deceased may be particularly vulnerable to suicidal thoughts and behaviour (Joiner, 2005). Psychologists have a key role in providing support and interventions to those affected by the death and psychological models may be applied to understand how individuals manage grief and adjustment following a death by suicide.

There is emerging evidence supporting beneficial effects of a number of interventions, including counselling postvention for survivors and outreach at the scene of suicide (Szumilas & Kutcher, 2011). In addition, evidence-based guidelines for responding to suicide in a secondary school setting have been published recently (Cox et al, 2016). However, further research is required into the effectiveness of postvention services and interventions on reducing suicide and attempted suicide/self-harm. Suicide deaths are often incredibly traumatic, the method of death is frequently violent and survivors are often plagued with the “re-experiencing” symptoms of trauma, such as flashbacks, nightmares and intrusive thoughts. These can occur even if the survivor did not witness the death scene. Re-experiencing, when accompanied with avoidance and hypervigilance symptoms, is characteristic of PTSD, and therefore counsellors need to be equipped to recognise and manage these symptoms or refer the person for trauma-focused cognitive therapy or another recognised PTSD treatment (NICE, 2005).

Suicide survivors may also be at risk of comorbid alcohol and other substance disorders, which may require treatment. Suicide has a huge impact on social relationships, there can be feelings of rejection and abandonment in addition to the burden of the loss. The death can also have a detrimental impact on social relationships and isolation due to the stigma surrounding the death and others’ beliefs about causes and blame. Individuals who are bereaved by suicide can feel unable to accept support and those close to suicide survivors often have difficulty responding appropriately and may even withdraw from the survivor (Grad, 2011). Therapeutic interventions should include helping the survivor manage and navigate social interactions, harness support networks and foster connectedness. Group support from other suicide survivors, or programmes which link survivors to others who have had a similar loss may be particularly useful for this reason (Jordan, 2011).

Organisational Postvention

The planned interventions with individuals and groups affected by a suicide death in a school or workplace are known as *organisational postvention*. Organisational postvention is a significant challenge and it is recommended that plans and protocols are put in place prior to a death. The goal of this type of postvention is in providing support to the bereaved, respecting their wish to honour the life of the deceased, without glamourising the death in a way that increases the risk of further suicidal acts. It is also important to do this in a way that respects the community’s cultural and religious beliefs, does not further contribute to the stigma of suicide or leave the bereaved feeling that the deceased has been demonised or punished (Berkowitz et al., 2011).

Response plans

Postvention response plans typically include the coordination of resources, dissemination of information and the provision of support for those most affected by

	<p>the death, or at risk of contagion. Psychoeducation regarding grief, depression and PTSD is an important component of postvention for those affected by the death. Organisational postvention should also include screening and case finding to detect people who are at higher risk of suicide, who may not come forward. Several screening and case finding tools are available for use in educational settings, however the identification of suicide risk based on screening tools is fraught with difficulties and many high risk individuals do not screen positive using such instruments (O'Connor et al., 2013). It is therefore important to foster an ethos of help seeking and compassionate peer support so that people can identify when others may be at risk and help them to seek support through clear support and referral structures. In the longer term, postvention should include the provision of opportunities for safe commemoration. It is advised that whilst commemoration should be no different for individuals who have died by any cause, permanent memorials, or events/awards in the memory of the deceased should be avoided, again to prevent contagion (Berkowitz et al., 2011). Broader mental health and resilience programmes may also be helpful in group settings such as schools, however these need to be selected carefully and implemented alongside effective referral pathways (Hawton, et al., 2015; Wasserman et al., 2012).</p>
	<p>The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy <i>Talk to me 2</i> and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.</p>
3.	<p>Comments:</p> <p>The Society has no comment to make.</p>
	<p>The contribution of the range of public services to suicide prevention, and mental health services in particular.</p>
4.	<p>Comments:</p> <p>Public Information Campaigns There is emerging evidence for increasing awareness via public information campaigns to improve the care for people diagnosed with depression and simultaneously address awareness and skills in early identification of suicide risk among healthcare and community-based professionals (Szekely et al, 2013; Hegerl et al, 2013), with proven synergistic effects of simultaneously implementing evidence-based interventions (Harris et al, 2016).</p>
	<p>The contribution of local communities and civil society to suicide prevention.</p>
5.	<p>Comments:</p> <p>Prevention "Early identification and effective management are key to ensuring that people receive the care they need." (WHO, 2014 p.9) There are two important aspects to prevention: as noted above: (i) understanding the factors associated with suicidal thinking/ideation with a view to reducing distress and (ii) reducing the likelihood that an individual</p>

makes a suicide attempt or dies by suicide. It is important to understand the psychological processes underlying each aspect as interventions must be tailored to each; for example, intervention at the suicide ideation stage would be specifically targeted at preventing progression to suicidal attempt. National suicide prevention strategies tend to adopt a dual track approach of implementing large-scale public health interventions, such as restricting access to lethal means of suicide as well as intervening with those at high risk (see WHO, 2014). High risk groups may include those who have self-harmed in the past; they are important group to target given the established relationship between self-harm and future death by suicide.

Restricting access to means

Restricting access to means involves implementation of measures to reduce availability of and access to frequently used means of suicide, e.g. drugs, fire arms, enhancing safety of bridges etc. Internationally, there is consistent evidence that restricting access to lethal means is associated with a decrease in suicide and that substitution to other methods is limited (Zalsman et al, 2016).

Education

Educating health care and community-based professionals to recognise depression and early signs of suicidal behaviour is important for determining level of care and referral for treatment, and subsequent prevention of suicidal behaviour (Wasserman et al, 2012; Coppens et al, 2014). Sustainability and capacity building of trainers and benefits in terms of knowledge, attitudes and confidence can be achieved via a Train-The-Trainer model (Coppens et al, 2014; Isaac et al, 2009). There are some indications for a link between improvements in intermediate outcomes (e.g. improved knowledge, attitudes and confidence) among health care and community-based professionals and primary outcomes, e.g. reduced suicide and self-harm rates (Mann et al, 2005; Hegerl et al, 2011; Zalsman et al, 2016).

Responsible Media Reporting

The importance of responsible media reporting of suicide in print, broadcast, internet, and social media is underlined by Niederkrotenthaler et al. (2014). The role of mass media has been shown to be effective in reducing stigma and increasing help seeking behaviour. There are also indications of promising results based on multi-level suicide prevention programmes (Niederkrotenthaler et al., 2014). A systematic review covering 30 studies on social media sites for suicide prevention (Robinson et al, 2016) showed that social media platforms can reach large numbers of individuals and may allow others to intervene following expression of suicidal behaviour. However, reported challenges include lack of control over user behaviour, possibility of suicide contagion, limitations in accurately assessing suicide risk, and issues relating to privacy and confidentiality.

Intervention - How effective are psychosocial interventions?

Preventing repeat self-harm is a crucial part of suicide prevention efforts since, as noted earlier, many who die by suicide have previously engaged in such behaviour (NCIS, 2016). The gold-standard method for assessing the effectiveness of interventions is a randomised controlled trial (RCT).

Adults

Recently, two systematic reviews have synthesized the worldwide RCT evidence on the effectiveness of interventions for self-harm (Hawton et al 2015, Hawton et al 2016a). These reviews demonstrate that there is now strong evidence that psychological therapies such as problem solving behaviour, dialectical behaviour

	<p>therapy (DBT) and cognitive behavioural therapy (CBT) (so called ‘talking therapies’) can effectively prevent the repetition of self-harm in adults (people aged 18 years old and over) (Hawton et al, 2016a, 2016b). They have also been shown to reduce the psychological distress associated with such behaviours (Townsend et al 2001, Hawton et al 2016a, 2016b).</p> <p>Under 18s For younger people (those aged under 18 years old) the evidence is very limited – with only eleven trials uncovered that have tested an intervention to prevent repeated self-harm in young people (Hawton et al 2015). Moreover, the evidence is more equivocal for psychological interventions in this age group (Townsend 2014; Hawton et al., 2015). So, for DBT (2 RCTs) and group-based psychotherapy (3 RCTS) meta-analysis revealed no significant effect in terms of reducing the number of people repeating self-harm (group therapy) or the frequency of self-harm (DBT). However, there is some evidence (from one trial) that mentalisation-based therapy, an integrative form of psychotherapy, may be helpful in preventing repeated self-harm (Rossouw et al 2012).</p>
	<p>Other relevant Welsh Government strategies and initiatives - for example <i>Together for Mental Health</i>, data collection, policies relating to community resilience and safety.</p>
6.	<p>Comments:</p> <p>The Society has no comment to make.</p>
	<p>Innovative approaches to suicide prevention.</p>
	<p>Comments:</p> <p>Electronic mental health interventions Electronic mental health (e-mental health) interventions represent a promising means of increasing the capacity for patients’ self-management of depression (Arensman et al., 2015). Using the Internet to deliver treatment for affective disorders has been shown to be an effective option for reaching patients who were not able to receive face-to-face treatment due to geographical or other situational barriers (Vallury et al, 2015) or to augment face-to-face therapy (Hoifodt et al, 2013).</p> <p>Electronic mental health interventions for mental health problems and mood disorders in particular have increased rapidly over the past decade. In recent years, an increasing number of e-mental health interventions have been delivered in the form of apps that are delivered via smartphones (Dogan et al, 2017). Available research underlines the value of smartphone-based approaches for gathering long-term objective data to predict changes in clinical states. However, the current evidence base does not provide conclusive information on the effectiveness and the risks of these approaches. Methodological limitations in this area include small sample sizes, variations in the number of observations or monitoring duration, lack of RCTs, and heterogeneity of methods (Dogan et al, 2017).</p>
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