While we are waiting to start...Take two minutes to write down your answer to the following questions on the sticky notes provided

Why you are here today?

What questions or concerns have led you to attend today's workshop?

What do you hope to get out of today?

You can give as much or as little information as you feel comfortable revealing.

There is no need to put your name on it, place them on the board or hand them to us.
Suicide and Self-harm - The Challenge for Front line Staff

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Overview of the workshop

Introductions

Why are you here and what do you hope to get out of the day?

Findings from research on patients presenting at A&E

Small group discussion

Findings from research on impact of working with suicide on front line staff

Small group discussion

Evaluation and next steps
Introducing you..

Say who you are

Which agency you work with and in what role
Why are we here today?
Sharon...
Suicide deaths registered in Northern Ireland 1970-2015

Source: http://www.thedetail.tv/articles/suicide-deaths-in-northern-ireland-highest-on-record
Kerry Why are we here today?

- Research and review findings (popn and young people)
- Needs of individuals presenting with suicidal ideation and self-harm is not always understood
- Findings - people will avoid presenting whenever possible
- Based on previous experiences - leading to further attempt
- Positive encounters - potential to change negative self-evaluation
- Ultimately rates have increased (i.e. MH services, economic, deprivation, life chances, employment/education opportunities)
Suicide and self-harm definitions

- **Self harm**: “An act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage and which is aimed at realising changes that the person desires via the actual expected physical consequences.”

- **Suicidal ideation**: “Acts of suicidal ideation include presentation to the ED by persons who have experienced thoughts of self-harm and, or suicide, where no physical act to harm oneself has taken place.”

- (Knowledge exchange seminar series (2015-2016) Queen’s University Belfast, The Open University, Ulster University; Platt et al, 1992)
What are some of the things that drive people to think about suicide or engage in self-harm?

- Personal catastrophes such as being made redundant, break up of a relationship, grief, conflict within the home or members of the community.

- A persistent sense of worthlessness or failure, uncertainty about sexual identity or personal goals.

- Ideas about successful life goals which they see other people doing such as getting married, going to university, getting new jobs, house etc. and being left behind.

- A combination of all the above together with a series of setbacks which can be devastating.
What is different about it?

- There might not be any that is easily discernible. An emotional crisis is not like having a broken leg, a cardiac arrest or stroke, there may not be any visible signs to begin with (self-harm).

- People who are in despair can be very skilled at hiding their thoughts and feelings. I am sure and I know that I have often been surprised to learn of people who have died as a result of suicide, and working with and researching the bereaved, they are often confused as someone seemed fine.
But they are likely to be feeling

- Cut off from everyone
- Frightened and ashamed about wanting to die
- Desperate for help but afraid to ask

“I’m usually in a state where I believe I am hopeless as I have failed to have the courage to go through with it.”

On avoiding others:

“I feel really scared as none of my family know and I now there is a family gathering tonight but I don’t feel strong enough to put on a front but I don’t have a good excuse for not going and I will be expected to be there.”
Feeling belittled:

“I felt stupid when I shattered my wrist, I was looked at with utter disgust like I was some kind of monster and treated from start to finish as if I was silly and not worthy of treatment.”

Positive responses:

“I was asked if a student nurse could observe and she was incredibly kind and asked why I had done this? She didn’t really understand it, but she was trying to.”
“The last time I had to have a blood transfusion and the consultant said that I was wasting blood that was meant for patients after they had operations or those who came because of road traffic accidents.”

“The doctor took a lot of care in stitching my wound up. When I told him this he said: ‘I don’t want you to leave with any scars.’ I just replied that I have a lot!. He said, ‘Not on my watch.’
Other examples

- Asking for blood samples as it could trigger
- Not having to roll up sleeves for BP due to scars
- Asking if it is ok to be seen by a clinician of the opposite sex
- Chatting in a random way to relax patients

BUT....

- A lottery of good and bad experience
- Not unique to ED After care - who is responsible - self care?
Small group discussion

Break into groups of four and discuss the research findings using the following questions:

- What was your immediate response to these findings on people presenting with self-harm?
- What did it bring up for you as a member of staff either working with patients or in supporting staff?
- What do you think it is important to ask? What to say?
  a. to the person presenting to you as a patient?
  b. a colleague who find this challenging and is looking to be supported?
Kerry- what others have said

- Attitudes and responses are a complex phenomenon and it is not just about having a positive or negative response.
- Compassionate vs ambivalence
- Frustration and distress
- Understanding why people do this vs not understanding
- Personal beliefs
- Personal /familial experience
- Social and cultural norms about mental health
- Less experienced compared with more experienced
- Front line personnel compared with those on medical ward
- Limited number of beds in A and E and transferring critically ill patients who don’t self-harm as a result
- Who should care for such individuals? Whose responsibility?
- Mental health services - depends on scope of services and availability
- What about you? The bigger picture
Common myths

(Wave 1 of the ‘Better Services for People who Self-Harm’ service user survey, April, 2006)

- **Myth:** People who self-harm are manipulative

- **Reality:** For many people their self-harm is a very private act. They may have self-harmed for years without telling anyone. For other people self-harm the only way of communicating at a time when they are deeply distressed.

- **Myth:** It’s best to ignore someone when they have self-harmed - they are less likely to do it again

- **Reality:** Rejection and feeling bad about oneself may be a cause of someone’s self-harm. Further rejection is likely to lead to further self harm!
Understanding self-harm
(‘Better Services for People who Self-Harm’ service user survey, April, 2006)

- Bewildering and shocking to others
- People can feel guilty, angry, unworthy, silenced
- A response to past trauma
- Abuse (physical, sexual emotional)
- Grief and bereavement
- Pressure to achieve
- Understood as an understandable response to a past trauma
- But how does this impact on staff?
Impact of caring work on mental health:
2014 NHS staff survey
62% AS staff disagreed or strongly disagreed that “in general my job is good for my health”
Mind blue light scoping survey

91% experienced stress, low mood or poor mental health

53% lived experience of mental health problems

25% had used mental health services

Mind blue light scoping survey

- 41% cited work as the main cause of their mental health
- Rating of support within organisations poor

Impact of exposure to suicide: Suicide cluster and suicide contagion tbc
Exposure to suicide in the general population

A random digit dial sample of 302 adults found:

64% of the sample knew someone who had attempted or died by suicide.

40% knew someone who died by suicide.

Almost 20% said they were a “survivor” and had been significantly affected by a suicide death.

Cerel et al (2013)
Exposure to suicide as part of your front line work ....you tell us?

How many front line staff were affected? We have no idea!!
Quantitatively it will be high 100%?? but the qualitative impact is as yet unexplored.

Results from Understanding Suicide Project: How many people were affected by each death by suicide?

- 1 death by suicide
- Overall people affected by the deaths of individuals: 3004
- 14 Family members
- 64 Friends
- 17 Members of the community
- 10 Work colleagues
- 5 Health care workers
Healthcare/medical professions have an elevated risk for suicide

Who is more at risk of suicide - male or female doctors?

Eva Schernhammer’s 2005 review found:
Female doctor suicide rate is about 130% higher than women in general population
The suicide rate among male doctors is 40% higher than the suicide rate of males in the general population.

The risk of suicide among female nurses is 23% above the national average (Analysis of data from 2011-2015).

Systematic review (Stanley, 2015)
Increased risk of suicide thoughts/behaviour/fatality amongst first responders
Very little data on risks / prevalence in EMT/paramedics
Employment and OH data

Demographics

- Eleven were male (73%)
- Mean age 42 (range 22-55)
- 9 were in patient facing roles, 3 worked in the AS call centres and 3 ‘other’
- All worked full time hours
- Mean length of service 16 years (73% >10 years)

Job role (n=9/15)

- Four of the deceased had a recent job role/location change
Employment and OH data

Occupational health (n=9/15)

- 4 had accessed the OH department
- 1 person declined OH support

Sickness (n=11/15)

- All had at least one episode of sickness over the study period
- Reasons included mental health (22%), musculoskeletal problems (17%), other problems (includes colds, coughs and gastro-intestinal reasons) (48%) and unknown reason (13%)
- Over half died within one month of returning to work
Coroner data

Suicide details
- Hanging most common cause of death (8/12, 66.7%).
- 3 individuals (20%) had morphine recorded in their toxicology report.
- Alcohol had been consumed in 4 cases.

Risk factors
- Relationship problems, disciplinary problems at work, and debt problems were each identified in 4 cases (36%).
- Loss of/restricted driving licence was identified in 3 cases (27%).
- 75% had a psychiatric disorder at the time of their death and approx a third had a history of self-harm.
Vignette 1:
Mick has been a paramedic in Derry/Londonderry for 10 years. In the past, he has responded to an individual who was contemplating suicide on the Foyle Bridge.

A few months, he was on holiday abroad and on a high bridge when he suddenly thought ‘that would be a good place to jump from’.

The thought terrifies him and he doesn’t understand where it has come from.

What should he do?
Vignette 2:

Jo has been an A&E nurse for 20 years. Over the past year she has treated Mary, an 19 year old, several times for an overdose of prescription medication.

While on shift one day Mary comes in having taken a large overdose and dies.

Jo doesn’t feel particularly affected by at the time and continues her shift but a few days later she dreams about Mary but in the dream her daughter, who is a similar age to Mary, also dies by suicide.

Mary can’t get it out of her mind. She becomes increasingly worried about her abilities as a nurse when dealing with individuals who present having taken an overdose.
Vignette 3:
Melanie is a A&E doctor. At university she attended a lecture in which the high rate of suicide among doctors was highlighted but she dismissed it at the time as she had never experienced any mental health problems.

A couple of years into her career, she was involved in the resuscitation of a young man named David who had hung himself after his relationship with his boyfriend had broken down.

A few months later Melanie finds out that her girlfriend has been having an affair and their relationship breaks down.

Late one night one night after drinking David comes into her thoughts. She wonders if he felt the same desperation she now feels. What should she do?
Some personal reflections

The trauma of the ‘unpreventable’ suicide.

The traumatic impact of being exposed to many difficult circumstances for which the response is a suicide attempt.

TBC....
General Self Care

the ‘actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health’ (Department of Health (DH), 2005.

Sharing responsibility:
Enlist support of colleagues or other health care professionals

Talk about it:
Talk honestly about your feelings, identify your own needs, and build on your coping strategies to better manage the situation.

Find out what are your professional support options.
Professional counselling, available through EAP or GP

Kerry any others????
Traumatic job or Traumatic Culture?

I'm a paramedic who has considered suicide and I'm not getting support

Yes we do a traumatic job but what makes it worse is a harmful management culture

Source: https://www.theguardian.com/healthcare-network/2017/jul/20/paramedic-considered-suicide-support-management
Group Discussion:

What do you think are the key issues for front line staff working with suicide in NI?

What can we do about it?
Changing the culture

Develop mental health strategy with suicide prevention focus that is based on evidence from frontline staff.

Business in the Community and Public Health England have online suite of toolkits to help every organisation support the mental and physical health and wellbeing of its employees. [https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-prevention-toolkit](https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-prevention-toolkit)

Additional Training and support for employees.

Screening??

Safety Planning with staff, if this happens....do this

Additional research is needed into particular times of stress.
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