Sussex Suicide Prevention Conference

Working together to prevent suicide.

in partnership with

GRASSROOTS SUICIDE PREVENTION

Having suffered from depression, anxiety and suicidal thoughts for many years, I have become accustomed to trying to remember that it’s OK not to be OK. You are not alone in finding things difficult and talking about these feelings helps.

Ben

Welcome

Emma Mills-Sheffield
Chair, Grassroots Suicide Prevention

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Survey Overview

- 84 conference attendees completed the pre-conference survey
- It aimed to help us identify strengths, challenges, and opportunities to suicide prevention improve efforts across Sussex

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Key Themes from the Survey

- Collaboration: Multi-agency partnerships and shared resources are needed.
- Funding and Resources: Lack of funding and staffing hampers efforts.
- Access to Services: Long wait times and service gaps affect access.

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Key Themes from the Survey

- Training and Support: Staff need more practical, hands-on training.
- Public Awareness: Early interventions and public education are crucial.

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Quotes - Challenges:

- "The stigma around talking about suicide remains strong in my experience, despite more awareness.“
- "Funding cuts, staff shortages in mental health services, and housing shortages are major challenges."
- "Economic pressures and housing instability are significant challenges that exacerbate mental health issues and increase the risk of suicide."

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Quotes – What would make a difference:

- "More funding to mental health services, more services available in evenings and at weekends.“
- "Wider access to training on suicide and suicide prevention to professionals and non-professionals, including input from those with lived experience.“
- "Better funding for local services which deal with the risk factors for suicide—loneliness, financial insecurity, discrimination, and exclusion."

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Quotes – Collaboration

- "Collaboration with housing and employment services could help address some of the wider determinants of mental health.“
- "Joint training initiatives and knowledge sharing between statutory services and VCSE organisations would help fill service gaps.“
- "Better collaboration between community mental health services and safeguarding teams could improve responses to those in crisis."

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Top Recommendations

- Strengthen collaboration across sectors
- Implement and build upon existing public education campaigns and training initiatives
- Increase funding for mental health and suicide prevention services

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Thank you!

- A big thank you to all those who shared their insights and creative thinking!

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The landscape of suicide prevention across the county; pan Sussex strategy and local based action plans

Darrell Gale, Director of Public Health, East Sussex County Council and Pan Sussex Lead on Suicide Prevention

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Sussex Suicide Prevention Conference

Darrell Gale
Director of Public Health, East Sussex County Council
Pan-Sussex Lead on Suicide Prevention

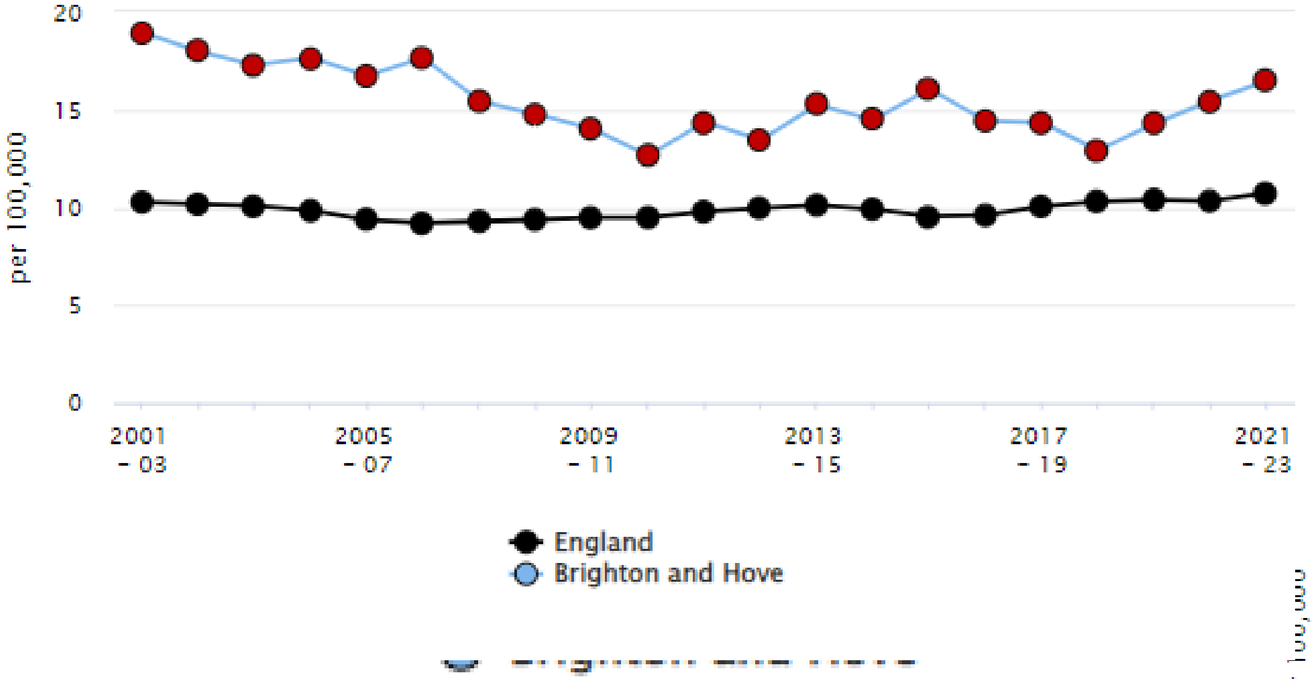
24 October 2024

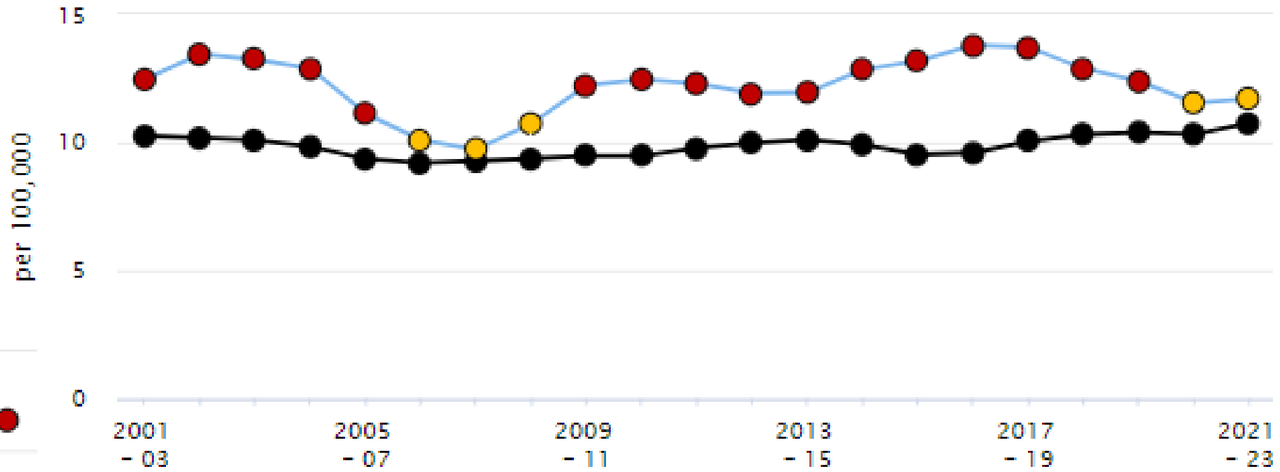
Suicide Prevention is Everyone's Business

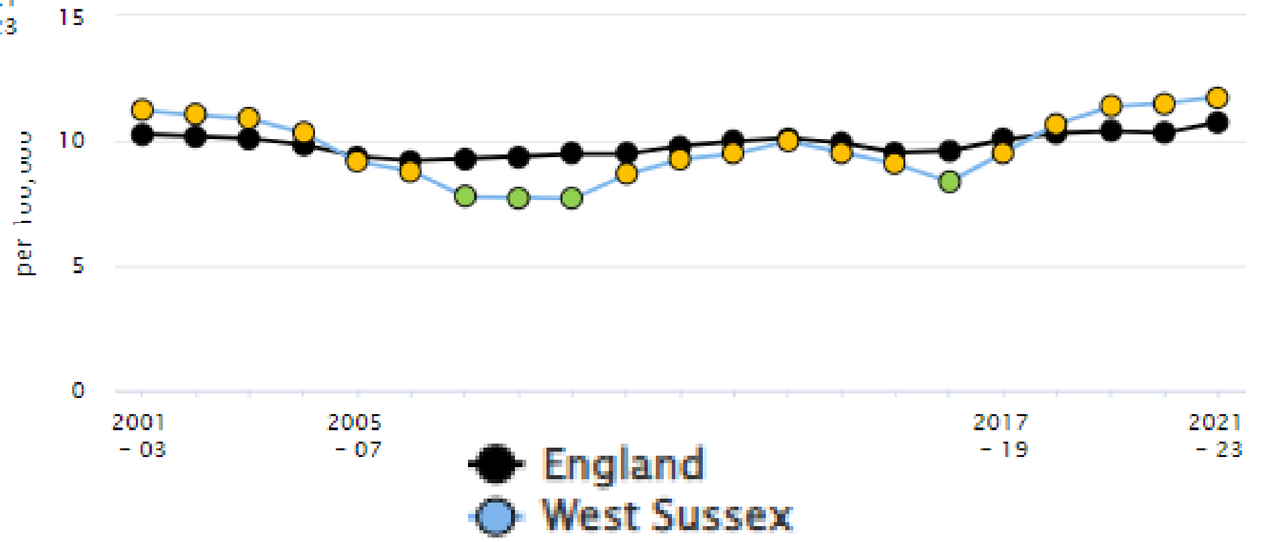
Hope

Pan-Sussex Suicide Prevention Strategy and local place-based action plans

Suicide rate (persons, 10+)

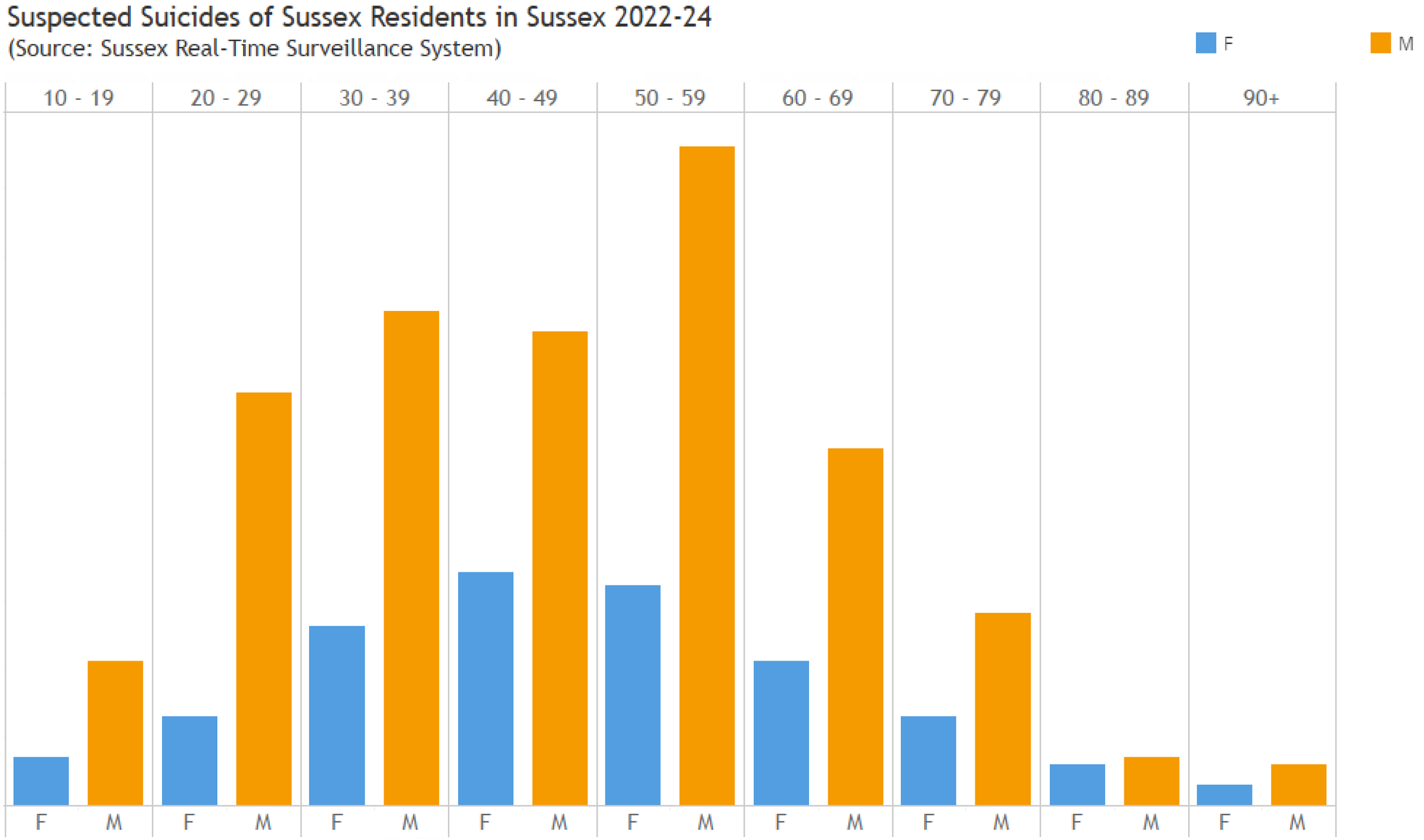




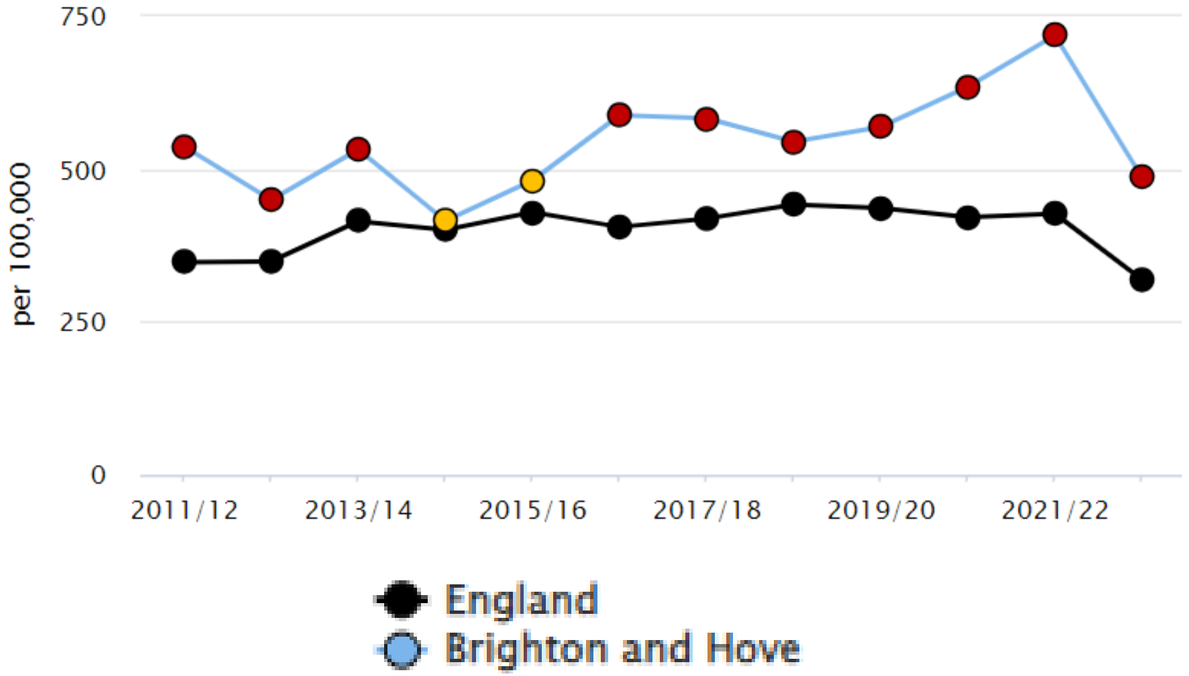


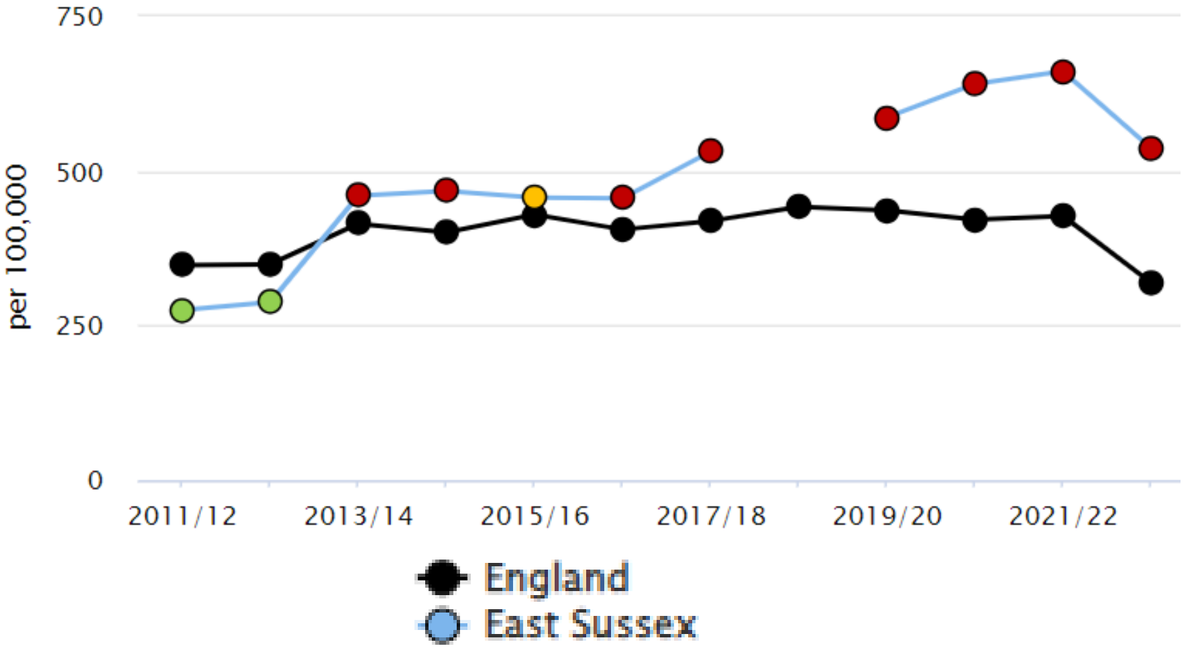
[Fingertips | Department of Health and Social Care]

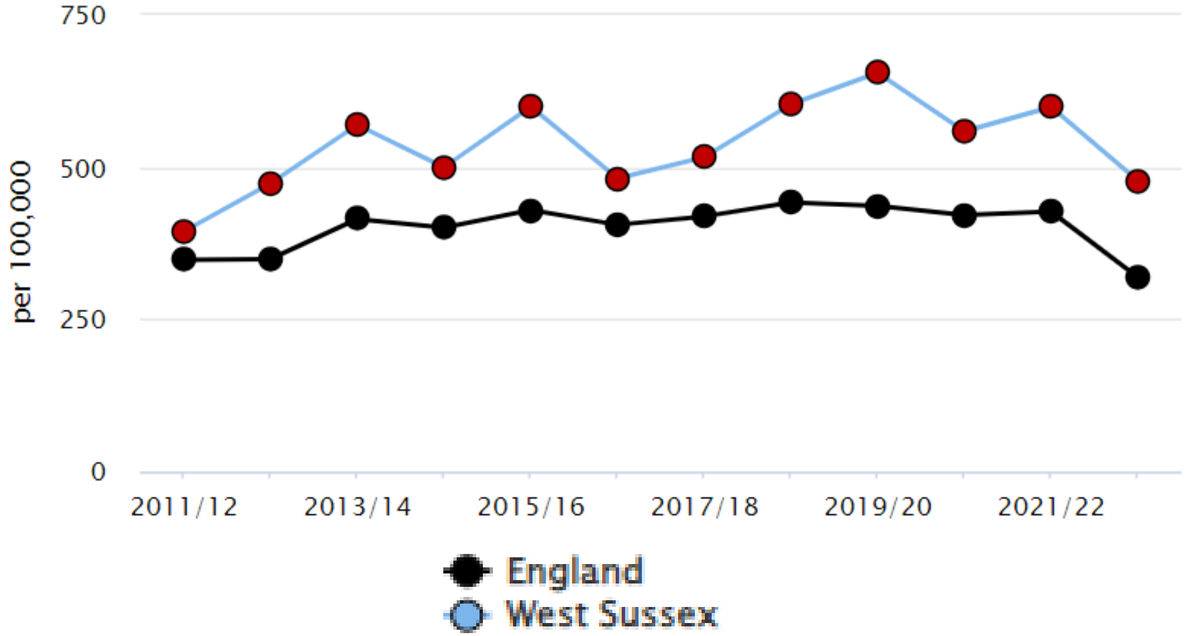
Variation by age and sex



Self-harm hospital admissions 10 – 24 years







[Children and Young People's Mental Health and Wellbeing | Fingertips | Department of Health and Social Care (phe.org.uk)]

Suicide Prevention – new national strategy

Published 11th September 2023 Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)

Priority groups

- children and young people
- middle-aged men
- people who have self-harmed
- people in contact with mental health services
- people in contact with the justice system
- autistic people
- pregnant women and new mothers

Risk factors at a population level

- Physical illness
- Financial difficulty and economic adversity
- Gambling
- Alcohol and drug misuse
- Social isolation and loneliness
- Domestic abuse

Sussex Challenges

Sussex

- Rates of admission for self-harm in those aged 10 to 24 are growing, statistically significantly higher than England for all three areas. Over last six years.

Brighton and Hove

- Very high and rising rates of suicide – sixth highest in the country
- Higher proportion of deaths in women – highest rate in the country.

West Sussex

- Rising rates of male suicides, trend above national average and trends
- High rates of self-harm in adults and children and young people

East Sussex

- Consistently high number of suicides at Beachy Head, with the high majority non-resident
- Higher than normal numbers of suicides in children and young people this year

Sussex Suicide prevention strategy 2024-2027 Aims

In line with the national strategy, the aims of the Sussex Suicide prevention Strategy and Action Plan are to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- improve support for people who have self-harmed.
- improve support for people bereaved by suicide.

Sussex Suicide prevention strategy 2024-2027
Vision

Sussex Health&Care

It is our vision that Sussex is a place where:

- we are committed to reducing the risk factors and increasing the protective factors for suicide across the life course
- we build individual and community resilience to improve lives and prevent people falling into crisis by tackling the risk factors for suicide.
- we recognise that suicides can be prevented, and that people do not inevitably end up considering suicide as a solution to the difficulties they face
- we create an environment where anyone who needs help knows where to get it and is empowered to access that help.

Local Suicide Prevention Frameworks and Action Plans - 2023 - 2027

East Sussex

- Accessible template for reports and policies in Word (green branding) (eastsussex.gov.uk)

Brighton and Hove

- BH suicide prevention Action Plan 2024-2027 - final.pdf (brighton-hove.gov.uk)

West Sussex

- Self-Harm and Suicide Prevention - West Sussex JSNA Website

Sussex Strategy – Priorities

1. Strengthen collaboration, system wide ownership and commitment
2. Improve suicide response / post-vention
3. Training / learning
4. Communications
5. Lived Experience
6. Self-harm

Hope

National picture on Mental Health and Mental Health Transformation

Sean Duggan OBE
Chair of Sussex Partnership NHS Foundation Trust

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Sussex Partnership NHS Foundation

Trust approach to suicide prevention

Peter Aitken, Chief Medical Officer,
Sussex Partnership NHS Foundation Trust

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Lived experience and suicide prevention

- Tasha Barefield, Engagement and Coproduction Lead, Possability People
- Olivia-Louise Hamilton, Suicide Prevention Lived Experience Advisory Group
- Fi Allen, Suicide Prevention Lived Experience Advisory Group
- John Featherman, Suicide Prevention Lived Experience Advisory Group

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Time for a break

Back in half an hour

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By engaging in therapy, taking medication, strengthening my support network, understanding my triggers and needs, and developing effective coping strategies, I've made remarkable progress. My journey proves that recovery is possible, even from the darkest places.

Olivia

Suicide Prevention Lived Experience Advisory Group member

Bridging the gap - supporting individuals with suicidality during waiting periods

Agnes Munday
Head of Training, Grassroots Suicide Prevention

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Breakout session - Option A

Meaningful safety planning for suicide prevention

Here in the Terrace room

Breakout session - Option B

Children and young people and suicide prevention

Gallery Room

Meaningful safety planning for suicide prevention

- Agnes Munday, Head of Training, Grassroots Suicide Prevention
- Dr Karen Lascelles, Nurse Consultant, Oxford Health NHS Foundation Trust
- Julie Cooper, Experience and Involvement Facilitator, Adult and Older Adult Mental health, Oxford Health NHS Foundation Trust
- Dave McNamara, Health Promotion and Training Lead, Change Grow Live

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Time for lunch

Back in 50 minutes

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Grassroots Suicide Prevention taught us how to spot and support people at risk when we're patrolling the seafront

David

I have learnt so much. I feel confident to talk about suicide now, to help others and I’ve been inspired by the people I have met on this journey.

Raquel

The truth about suicide and the impact that a death by suicide has on those bereaved

Dr Rachel Gibbons, Consultant Psychiatrist

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The 'Truth' About Suicide

Dr Rachel Gibbons

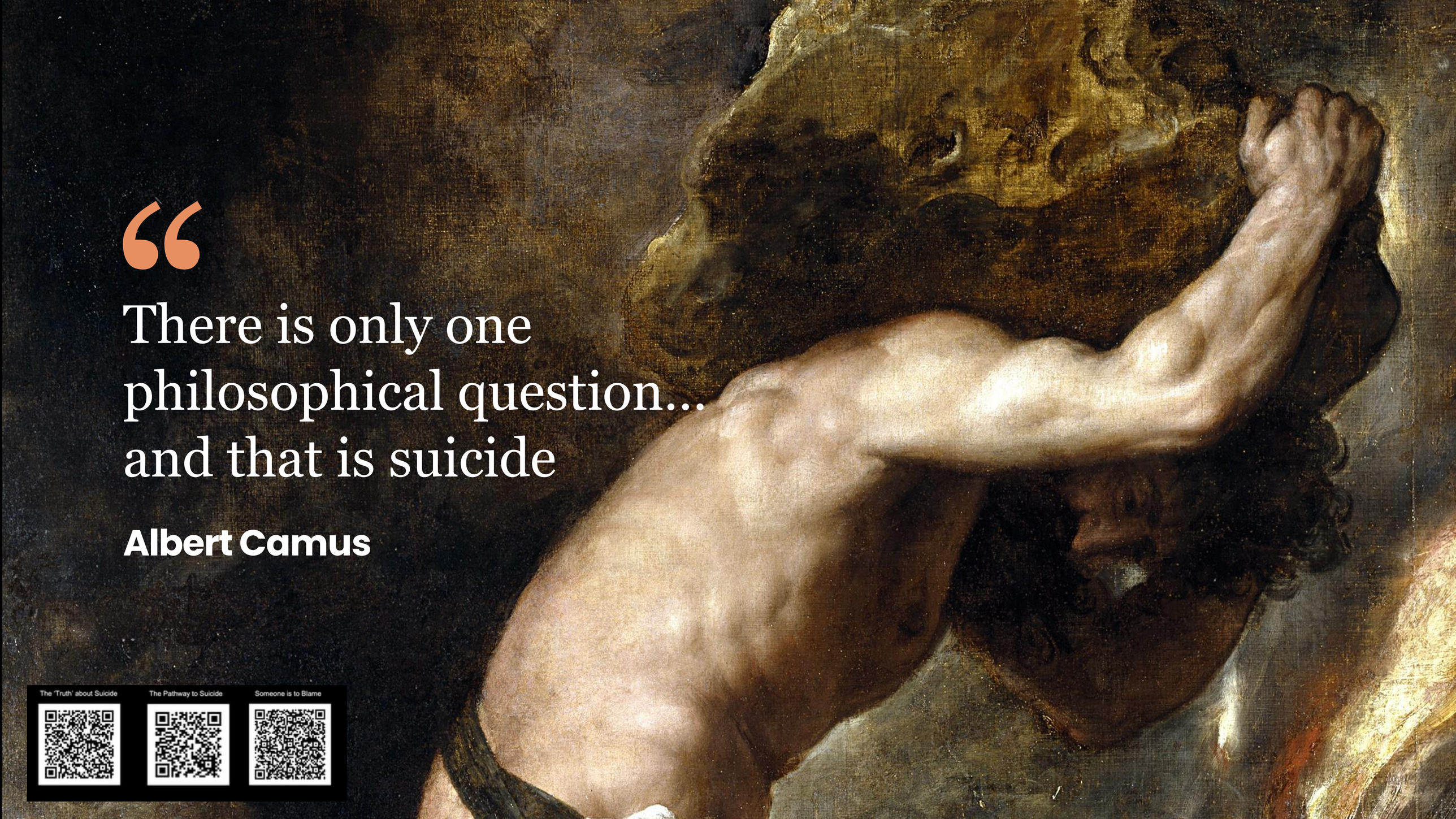
Consultant Psychiatrist, Psychoanalyst, Group Analyst | Chair of the Royal College of Psychiatrists Working Group on the Effect of Suicide and Homicide on Clinicians | Vice-Chair Psychotherapy Faculty | Co Chair of the Patient Safety Group

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

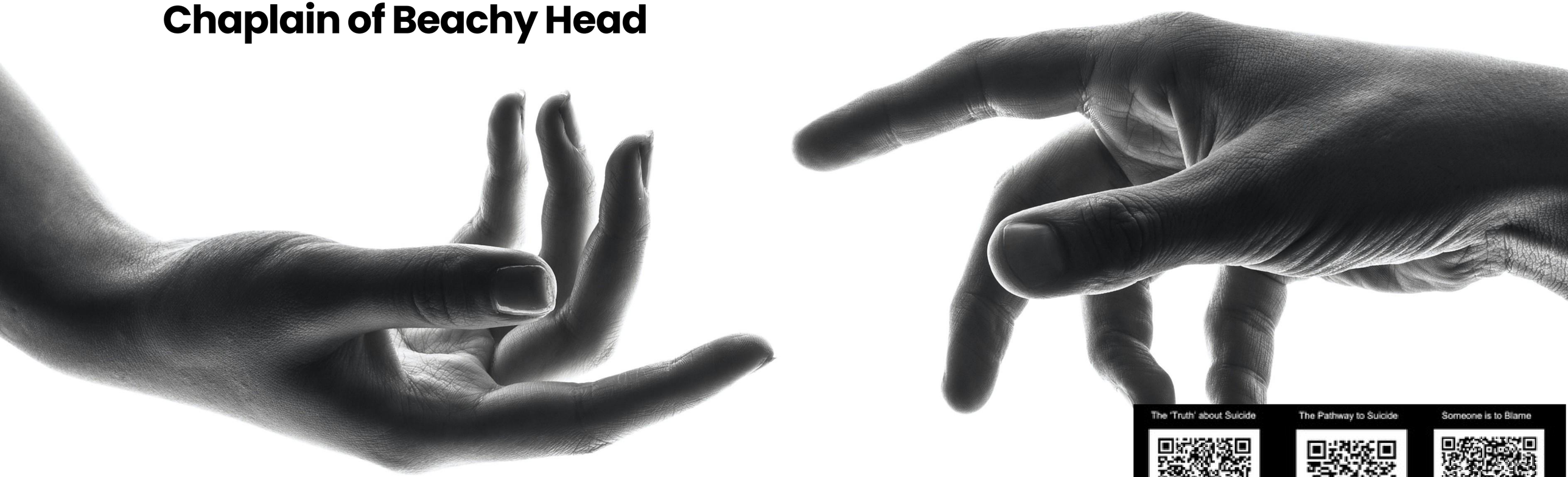
Sanity is Soothing


“
There is only one philosophical question... and that is suicide
Albert Camus
The ‘Truth’ about Suicide
The Pathway to Suicide
Someone is to Blame


The only way out
is through
The 'Truth' about Suicide
The Pathway to Suicide
Someone is to Blame

“To help a truly suicidal person you have to approach them with an open heart…

Chaplain of Beachy Head



The ‘Truth’ about Suicide

The Pathway to Suicide

Someone is to Blame

Truths
About Suicide

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

1.
Suicide is not an accident

- Suicide is not an accident
- It is a result of complex universal unconscious mental mechanisms that we do not understand
- It can be highly determined

2.
You will never know why someone has died by suicide

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

3.

Impulsive vs premeditated

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

4.
You do not know what is going on in someone else's mind

The 'Truth' about Suicide

The Pathway to Suicide

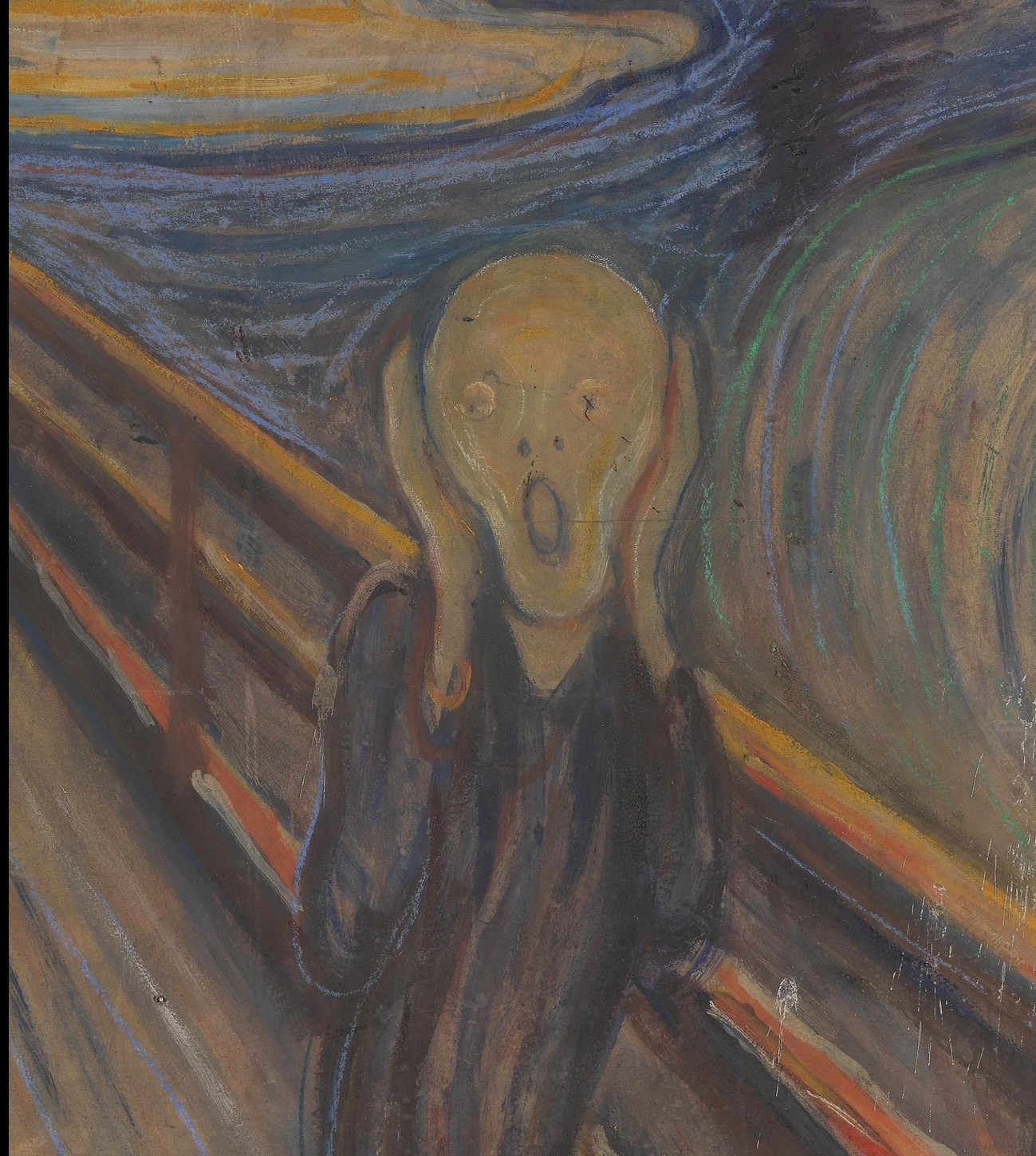
Someone is to Blame

5.
Everyone is shocked and surprised by the death

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame



6.
Suicide result from an incapacity to mourn

The 'Truth' about Suicide

The Pathway to Suicide

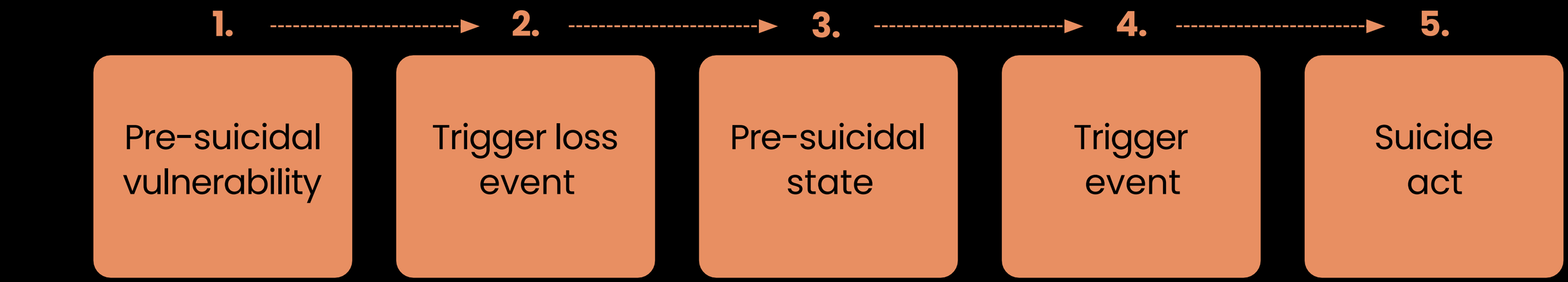
Someone is to Blame

Pathway to Suicide

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame



Gibbons, R., 2024. Understanding the psychodynamics of the pathway to suicide: *International Review of Psychiatry*, pp.1-9

7.
Suicide is a human condition not a mental health condition

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

8. Suicide prevention challenging in any individual case but not on a population or conceptual level

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

9.
Suicide is an acting out event

You act out when you cannot put your emotional experience into words

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

“

An act like this is prepared within the silence of the heart, as is a great work of art. The man himself is ignorant of it. One evening he pulls the trigger or jumps

Albert Camus

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

Facts or Truths about suicide

1. Suicide is not an accident
2. You will never know why someone died by suicide
3. It is either impulsive or premeditated
4. You do not know what is going on in someon elses mind.
5. Everybody is shocked by the death
6. Suicide appears to result from an incapacity to mourn
7. Suicide is a human condition and not a mental health condition
8. Suicide prevention is a public health issue and talking about it reduces the risk
9. Suicide is an acting out event

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

10.
No one is to blame for someones death by suicide

- Blame is a non-mentalizing word
- It only allows for one - and the complexity and uncertainty of the situation are not considered.
- Responsibility is a mentalizing word

It’s is our belief that we can predict and prevent individual suicide that makes us the architect of our own downfall following the suicide of a patient. We then take suicide of a patient as our own failure The truly suicidal then pose a risk to us …and It makes us less likely to approach them with an open heart

Gibbons, R., 2023. Eight ‘truths’ about suicide. *BJPsych Bulletin*, pp.1-5

The Impact of Suicide on the Mind of the Bereaved (Including Clinicians)

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

Facts or Truths about suicide

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9. Suicide is an acting out event
10. No one is to blame for anyone else death by suicide

The Multiple Impacts of suicide

- Shocking annihilatory loss
- Uncertainty
- Fracturing of fragile construct of life
- Projected into by the person who has died- suicide acting out
- Destructive nature
- Leads to a fragmentation of the mind
- Delusion generated

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame

Image Jenny Saville

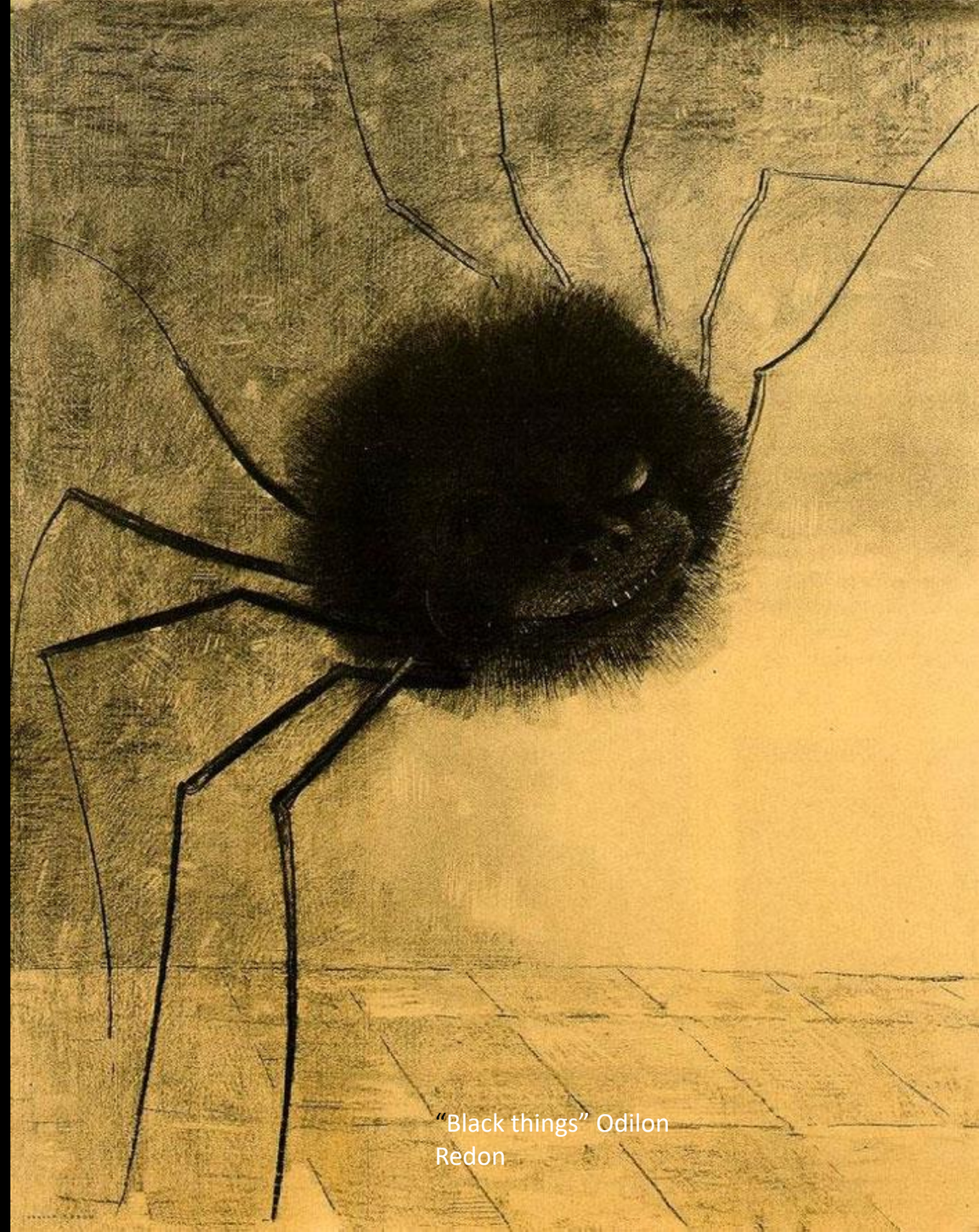
‘the delusion is found applied like a patch over the place where originally a rent had appeared in the ego's relation to the external world’.

Freud: Neurosis and Psychosis

The 'Truth' about Suicide

The Pathway to Suicide

Someone is to Blame



“Black things” Odilon Redon

Pattern of Response

- Initially shocked
- Within short space of time a delusional narrative is constructed
- The bereaved as the protagonist
- Obsessional ‘I have made a mistake – I am to blame’
- Guilt/shame/humiliation
- Important transitional point- sensitive to external response
- Gradually more realistic development

The ‘Truth’ about Suicide

The Pathway to Suicide

Someone is to Blame

Premonition by Henryk Weyssenhoff

Clinicians Suffer Disenfranchised Grief

- There is not enough grief to go round
- “I have no right to feel grief because the families grief is so much worse”
- “If I ask for any space for my feelings then it will take away, or compete with, the families grief”

The ‘Truth’ about Suicide

The Pathway to Suicide

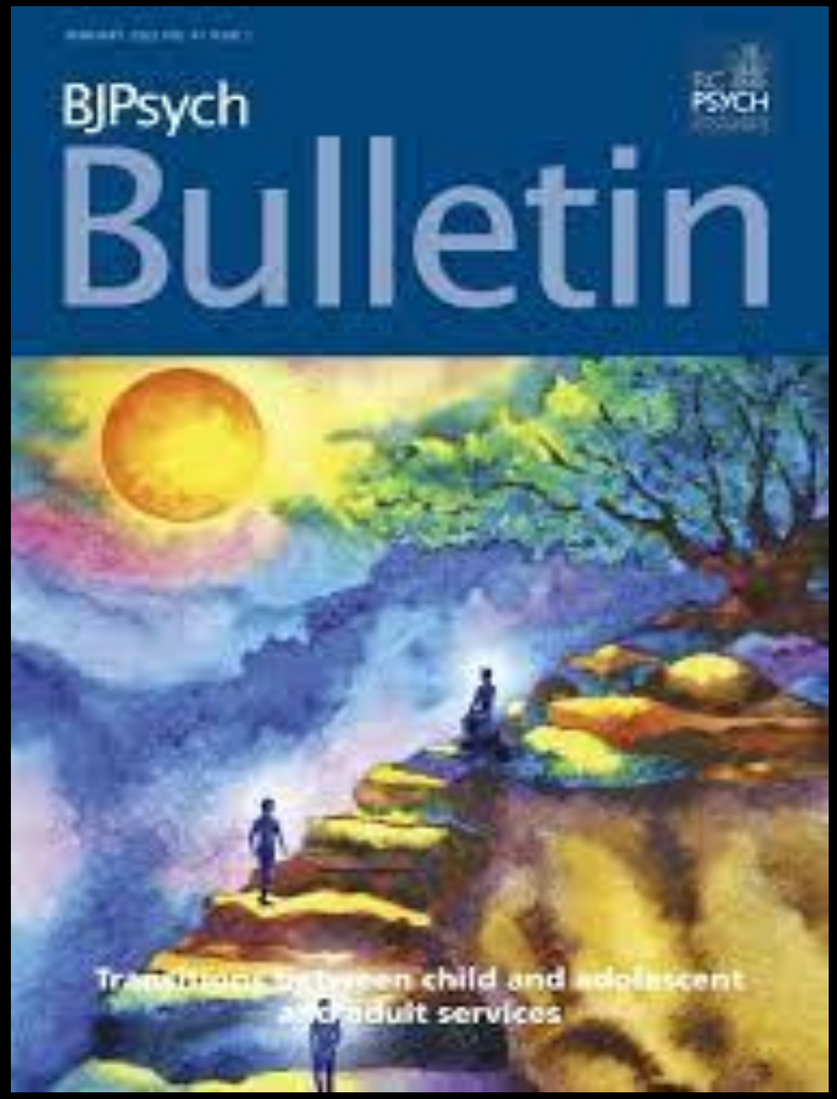
Someone is to Blame

Gibbons, R., 2024. Someone is to blame: the impact of suicide on the mind of the bereaved (including clinicians). *BJPsych bulletin*, pp.1-5.

Hope George Friderick

Effects of patient suicide on psychiatrists: survey of experiences and support required

Gibbons, R., Brand, F., Carbonnier, A., Croft, A., Lascelles, K., Wolfart, G., & Hawton, K. (2019) *BJPsych Bulletin*, 2019 1-6

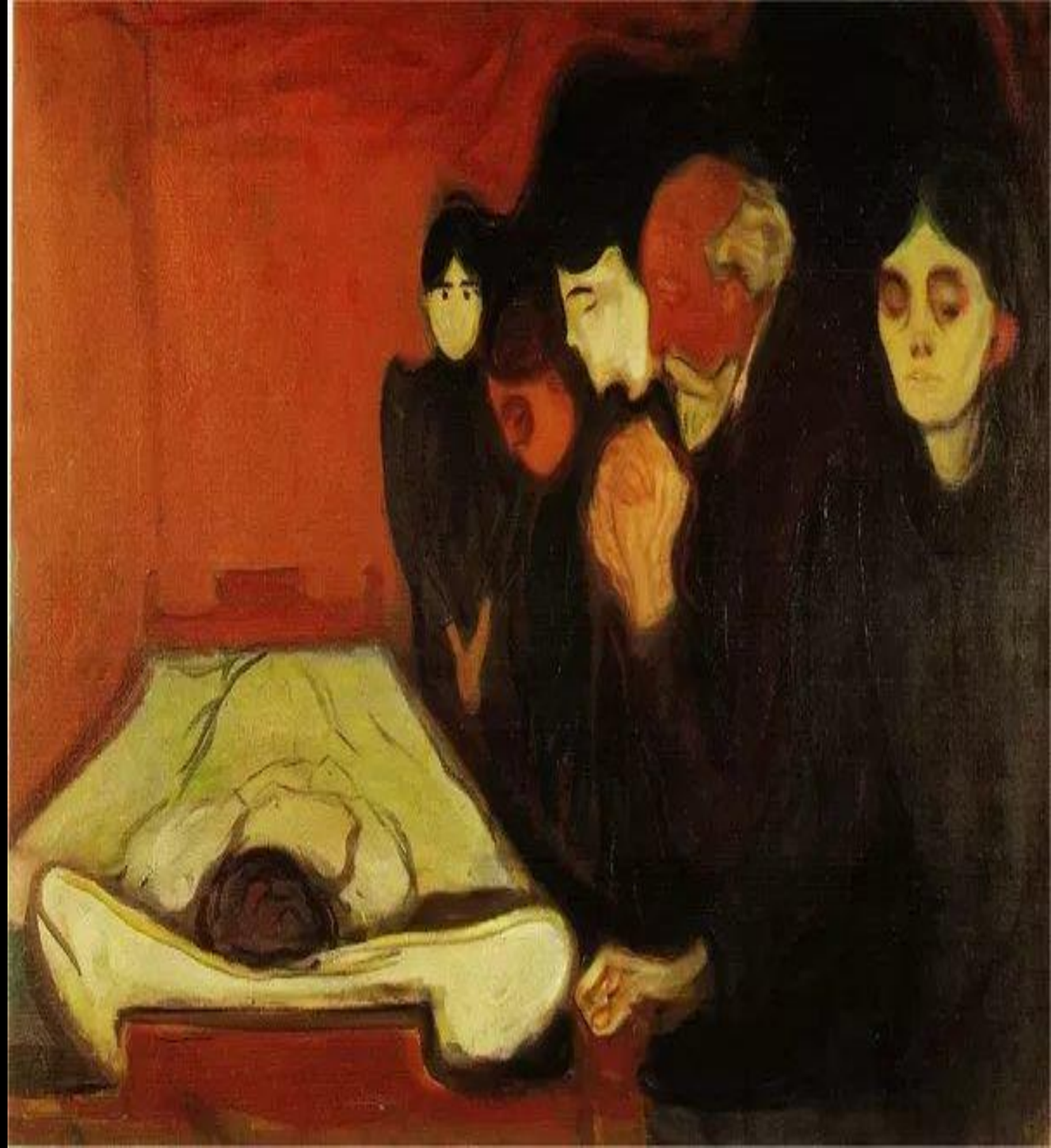


Emotional Impact

“initially shock and intrusive memories - things deteriorated after a month so tearfulness, unable to focus, intrusive thoughts and memories, nightmares resentment, shame, helplessness, finally PTSD”

“like being deeply wounded”

“I feel it's something I'll have to carry forever. I think of the boy often. ...One thought I had at the time (and still have) is that if I had another suicide then I'd resign and do something else with my life.”



Change in Career

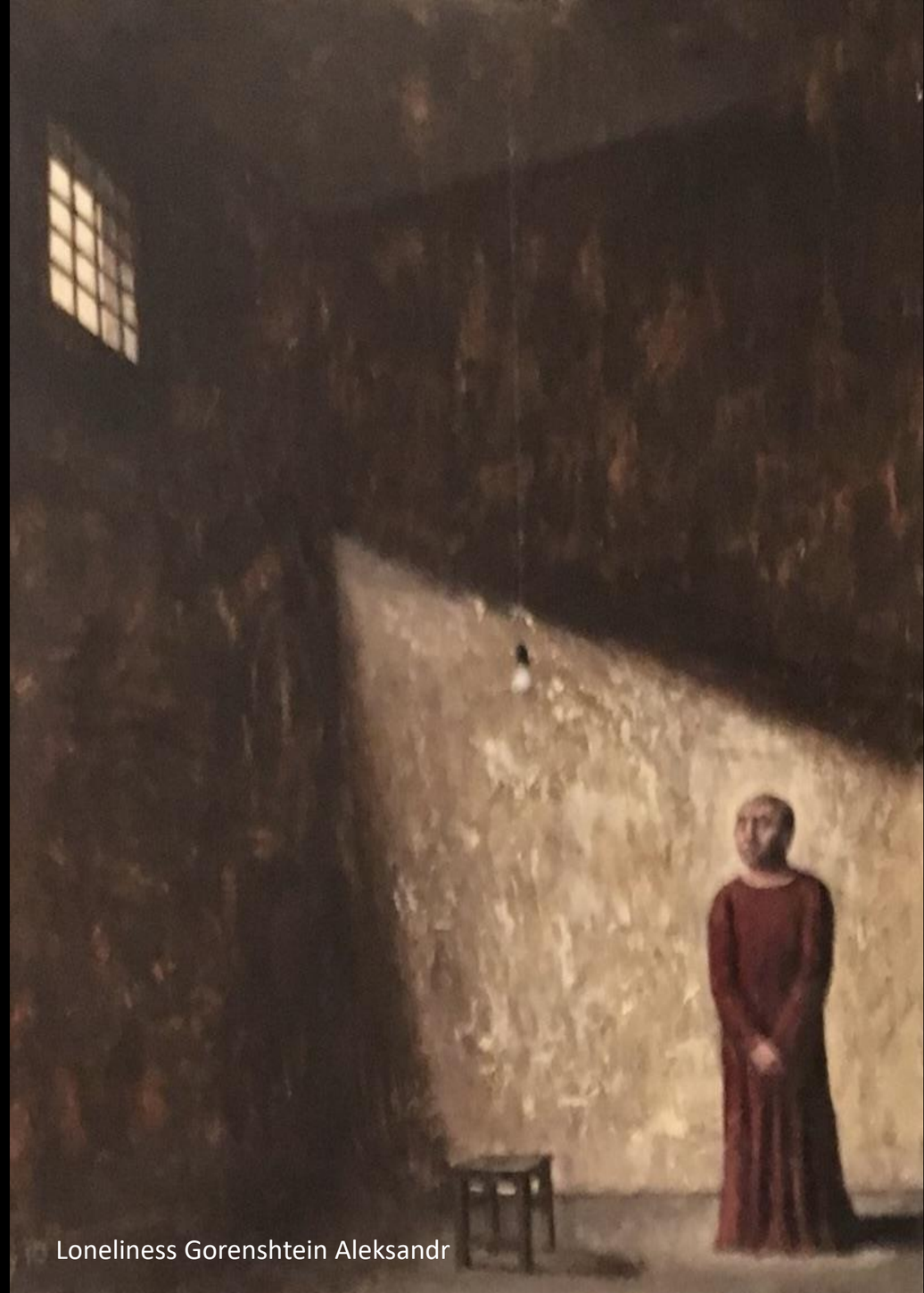
"The effect of this death heightened my determination to retire as soon as possible"

- Many considered changing career
- Of 16 consultants and 1 SAS doctor experienced an impactful suicide in training in GA only 1 continued to work in this area

Predictability and Preventability of suicide

"It is a very frightening world where one professional group is given an impossible task and then censured by society (and themselves) for failing to achieve it."

- Two-thirds of respondents rated their role in suicide prevention between 'to some degree and 'very much'
- Women > men
- On average respondents thought that suicide is predictable to 'some degree'



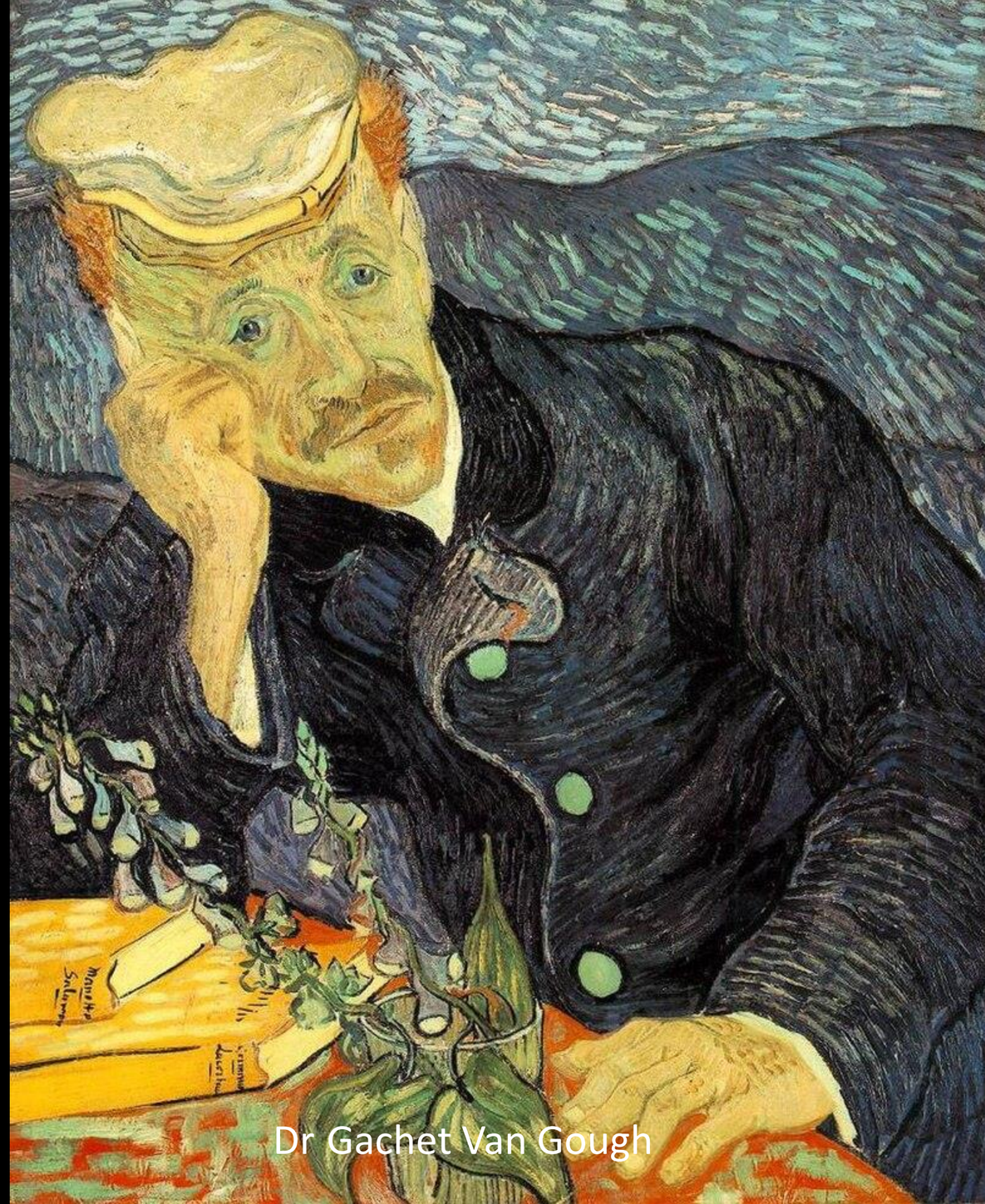
Loneliness Gorenshtein Aleksandr

Effect on Clinical Duties

"Ongoing thoughtfulness about patient contact – made me more vigilant and risk conscious"

- 98% reported detrimental effect on clinical practice
- Women affected more than men

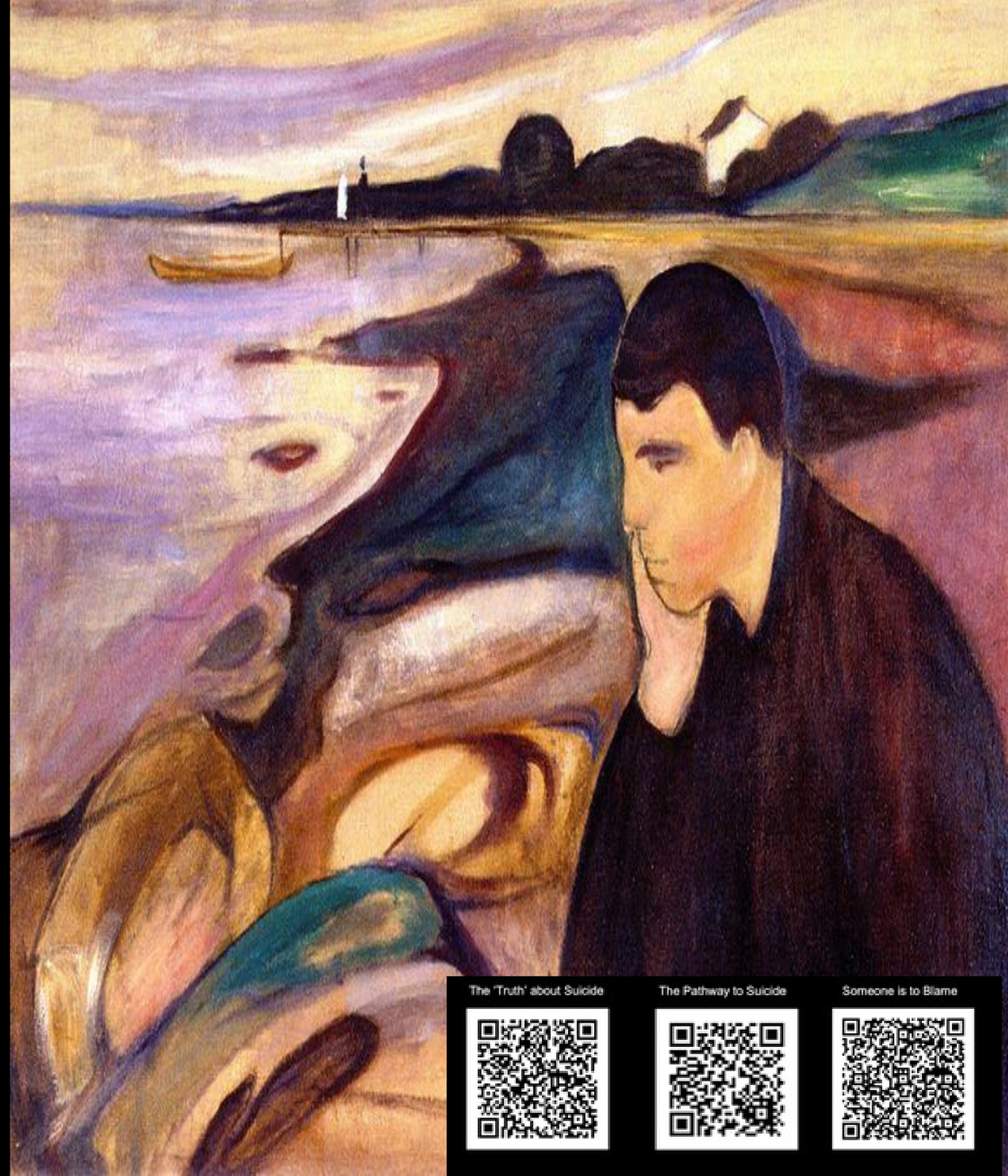
- Effect lasted:
- 1 week – 6 months 39%
- 6 months – 2 years 21%
- Ongoing – 13%



Dr Gachet Van Gough

The Effect of Suicide on Clinicians

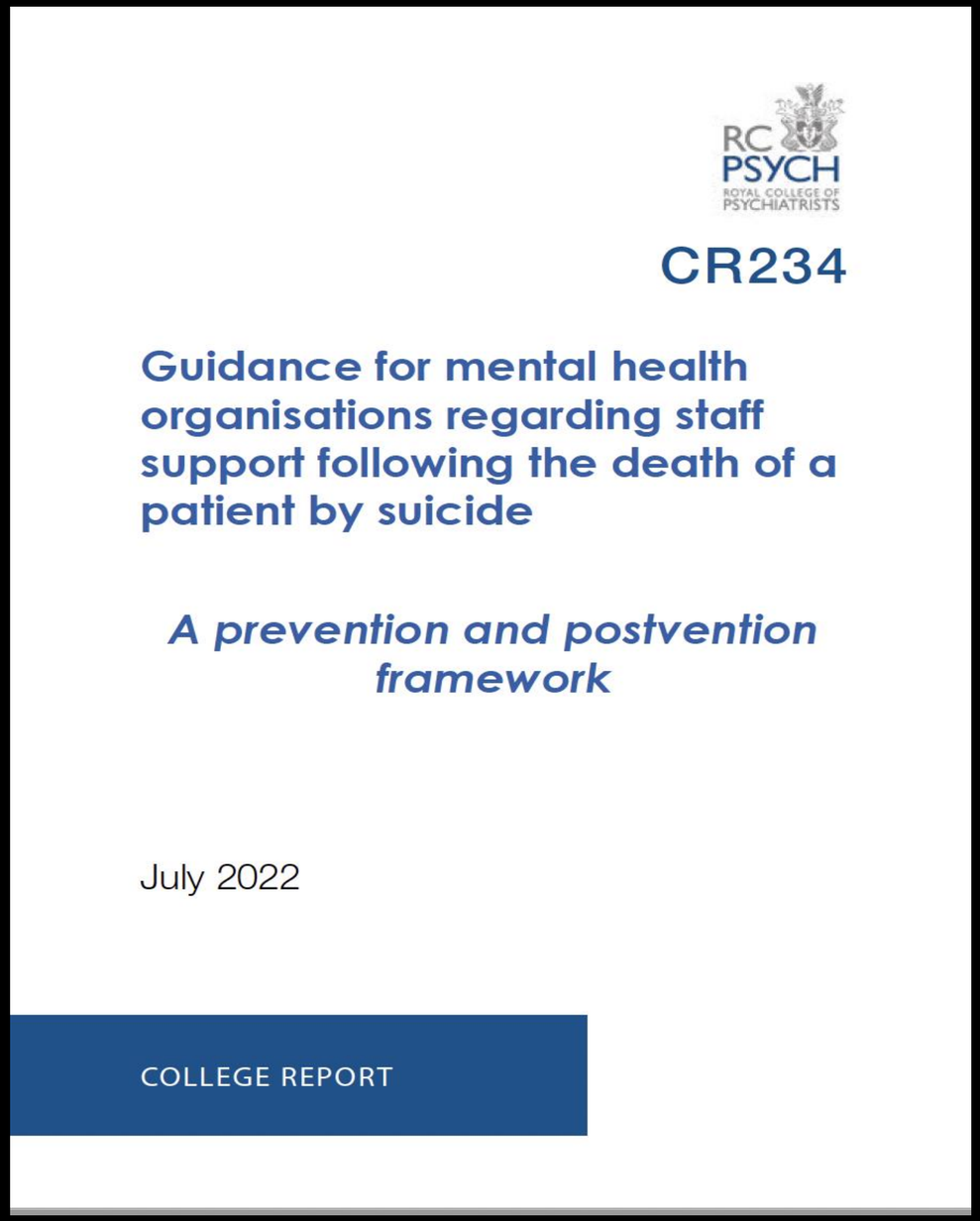
- Profound unacknowledged trauma
- External responses (inc: organisational and societal) can amplify or mitigate
- The fear of persecution following suicide - lead to an overvalued interpretation of the role as predicting and preventing suicide.
- This distorts the meaning of the work
- The focus on working with patient to improve the quality of their life can be lost and open hearted engagement is not possible



Our Omnipotent Role

- We see our task as doing the impossible
- Controlling what cannot be controlled
- Predicting and preventing individual suicide – at all costs
- Even though there is no evidence that this can be achieved
- AT THE COST OF OUR PRIMARY TASK

Atlas holding up the celestial globe Guercino


RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS
CR234
Guidance for mental health organisations regarding staff support following the death of a patient by suicide
A prevention and postvention framework
July 2022
COLLEGE REPORT

Aims of New Guidance

1. **Recommend evidenced-based and best practice interventions to:**
    1. mitigate the impact of a patient death by suicide
    2. improve the sustainability of mental health services increase staff wellbeing, progression with training, resilience and retention.
    3. assist mental health and training organisations in their legal obligation of duty of care for their employees
2. **Increase awareness of the impact that a death of a patient by suicide can have on professionals and to:**
    1. encourage transparent and open dialogue about the impact on staff of working with suicide risk and death.
    2. facilitate expansion of suicide prevention and awareness training to include preparation for the emotional effects and the processes that follow the death of a patient by suicide.
3. **Help support cultural transformation:**
    1. from one where individual clinicians may feel isolated and personally held responsible following a death, to a systemic understanding about the uncertainty and complex aetiology of suicide and its consequences on staff.
4. **Improve the quality of patient care:** by helping staff feel less anxious working with suicidality and in this way maintain their capacity to think clearly and provide safe, high-quality, care.
5. **Increase the possibility of truly learning from these tragic events.** To learn takes time, space for reflection and freedom from persecution.

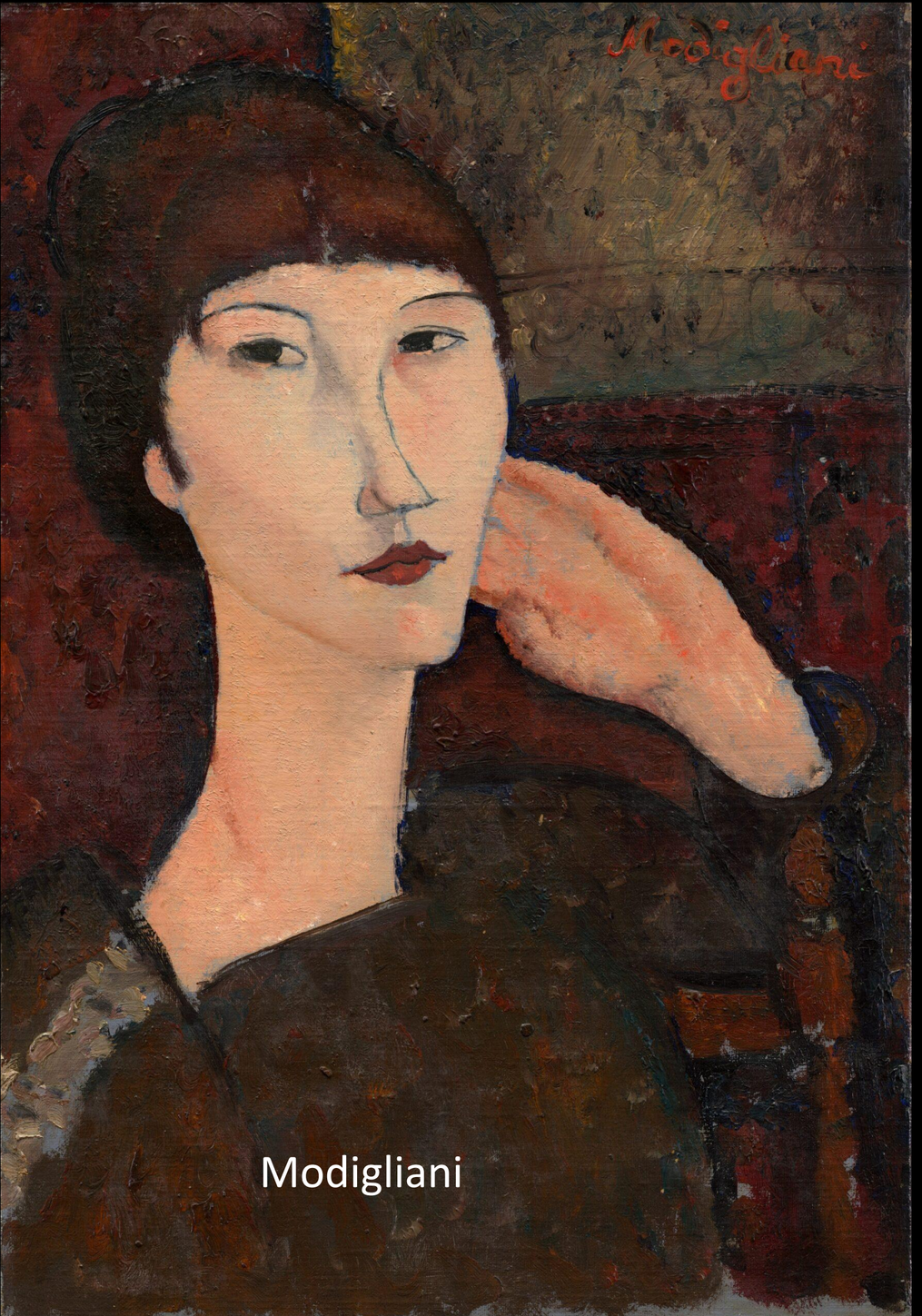
Checklist for senior management teams (SMT) and managers of affected clinicians

Prevention

Staff wellbeing	Have you provided regular health and wellbeing conversations with your staff, or delegated the provision of these conversations to an appropriate individual? The NHS website has helpful information on safe and effective wellbeing conversations.	
Team training and information	**Have you provided training on:**	
	1. The emotional effects of a patient's suicide on clinicians, and what may or may not be helpful?	
	2. The processes that follow including the serious incident inquiry and the Coroner's Court?	
	3. How to write and present a statement to the coroner?	
	4. How to investigate a serious incident in an impartial way, that is supportive to staff and teams?	
Team culture	**Do you:**	
	1. Foster a safe, open team culture?	
	2. Regularly have discussions about serious incidents and use them to normalise emotional responses?	
	3. Encourage employees to access support in and outside of the team whenever it is needed?	
	4. Have links with occupational health?	

Postvention (first few days)

Type of support	Actions	Tick (✓) box when completed
Immediate protocol	**Have you met to communicate and delegate tasks, including:**	
	1. Communicating with the family of the deceased (see below)?	
	2. Identifying and thoughtfully informing staff members involved?	
	3. Offering condolences to staff involved?	
	4. Identifying who will liaise with internal and external agencies?	
Immediate support	**Have you:**	
	1. Thought about your own support needs?	
	2. Offered health and wellbeing conversation to staff involved?	
Liaising and further team support	**Have you:**	
	1. Linked up with the trust/organisation's suicide prevention lead and identified local support resources available?	
	2. Considered in collaboration with team mangers, if any staff members need work adjustments, compassionate leave and/or referral to occupational health?	
	3. Organised a facilitative pastoral reflective space for all clinicians involved to come and talk together – both in the first week and the following month?	
	4. Liaised with the GP?	



Modigliani

UK Recommendations

1. Organisational pastoral suicide lead role
2. Pastoral senior management support
3. Support for the processes following the death
4. Buddy systems and other individual support
5. Group psychological support including a organisational suicide group
6. Family liaison officer (FLO), service or similar
7. Training on the effect of patient suicide on clinicians and on the processes that follow
8. Resource availability

Gibbons, R., 2023. Eight ‘truths’ about suicide. *BJPsych Bulletin*, pp.1-5.

Gibbons, R., 2024. Someone is to blame: the impact of suicide on the mind of the bereaved (including clinicians). *BJPsych bulletin*, pp.1-5.

Gibbons, R., 2024. Understanding the psychodynamics of the pathway to suicide: *International Review of Psychiatry*, pp.1-9.

The ‘Truth’ about Suicide

The Pathway to Suicide

Someone is to Blame

Breakout session - Option A

High risk locations – what have we learnt so far, plans and progress

Here in the Terrace room

Breakout session - Option B

Neurodivergence and suicide prevention

Gallery Room

High risk locations – what have we learnt so far; plans and progress

Darrell Gale – Director of Public Health, East Sussex County Council

Gus Pickett – Team Supervisor, Beachy Head Chaplaincy Team

East Sussex County Council

BHCT BEACHY HEAD CHAPLAINCY TEAM

Welfare Information

- This presentation discusses methods and places of deaths by suicide
- We share these in the context of preventing further suicides, in which we all play an equal role
- Lived experience is an important contribution, and not all people with lived experience wish to declare this
- Look after yourself and others, and don’t feel obligated to participate

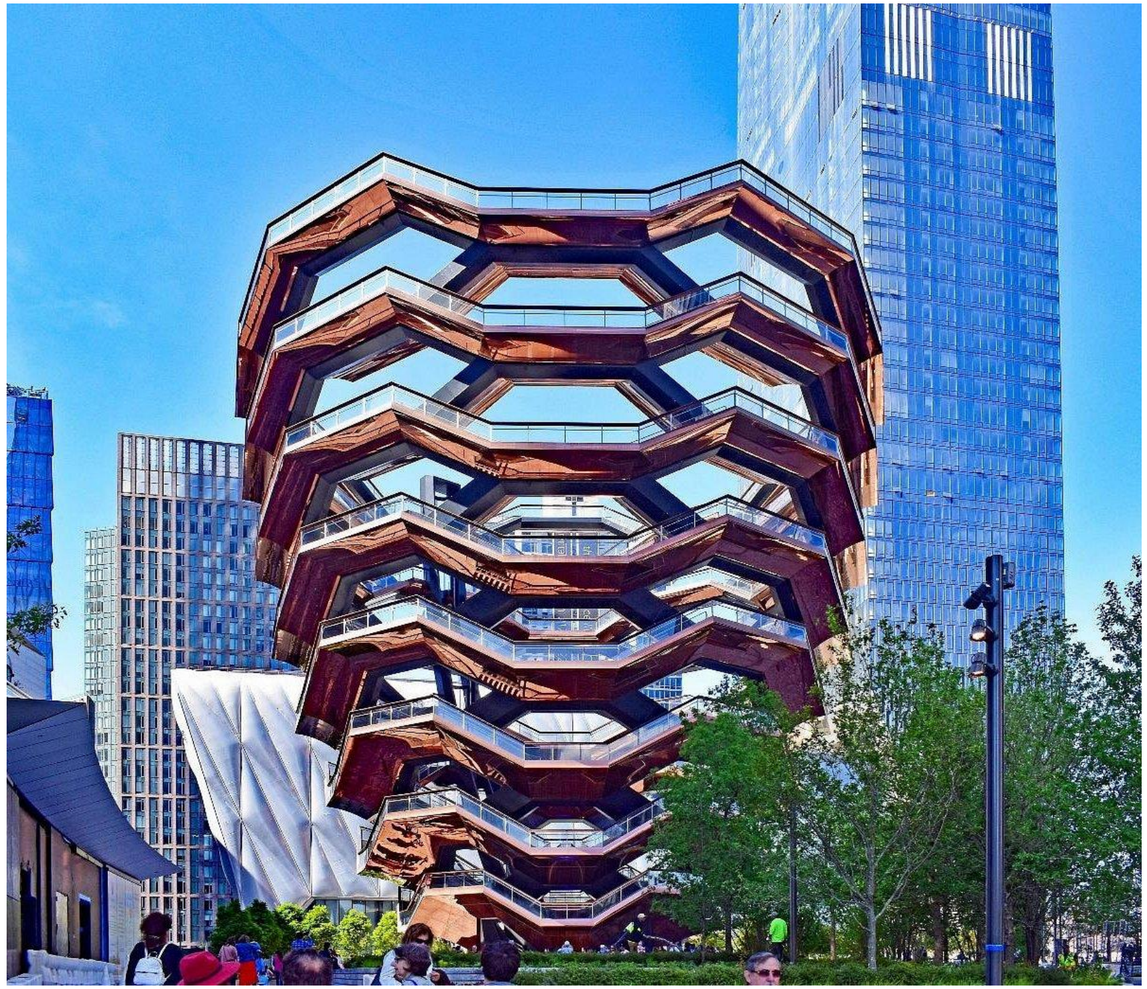
High Risk / Frequent / Public Locations

Around a third of all suicides take place outside the home, in a public location of some kind.

They attract harmful media attention and can have significant psychological consequences for those, including children, who witness them or discover a body.

They may also directly involve another person, such as a train driver.


8
Car stop
NO TRESPASSING
Passengers are not permitted beyond this point.
Use the subway or footbridge to access other platforms
DANGER
Risk of serious injury or even death.
STAFF ONLY
Staff permitted to access the track must comply with safety instructions
TALK TO US
116 123
Chadwell Heath (London End)
Train Driver Announcement Information
Date:
Time:




Da

Common Factors

Ease of access

Few gatekeepers

Seclusion / Privacy

Distinct means of suicide

Certainty of death

A quest for peace and solitude

A love of nature and the outdoors

A desire to spare loved-ones the distress of finding them

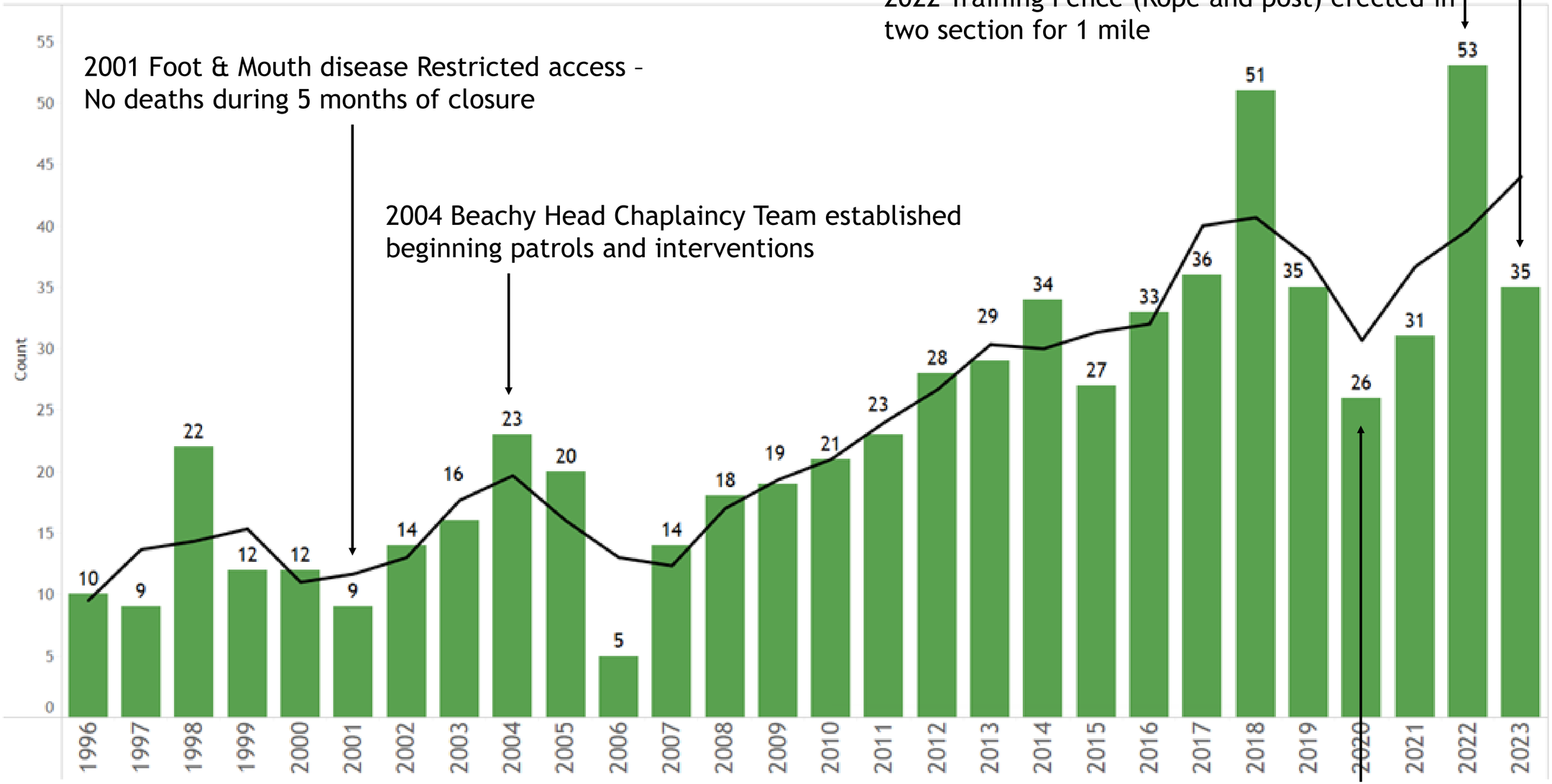
The possibility of rescue

Our Most Frequent Location

- Over 6 miles of continuous, mostly vertical cliffs at lethal height without any barriers
- All with free open public access – not even stiles/gates
- Public road and bus stop within 15 steps from the cliff edge
- Minimum of 45 minutes' walk from Eastbourne Station to highest point
- Bordered by a thriving town of 100,000 people yet has no natural surveillance from the town
- Known throughout the world as a suicide destination which is reinforced by long-established cultural references and metaphors for despair
- The numbers dying continue to grow despite agencies doing all they can do
- This unique challenge requires unique responses

Beachy Head Long-Term Data

Concluded or Suspected Suicides (Seven Sisters to Holywell) with 3-point Moving Average



2001 Foot & Mouth disease Restricted access – No deaths during 5 months of closure

2004 Beachy Head Chaplaincy Team established beginning patrols and interventions

2022 Training Fence (Rope and post) erected in two section for 1 mile

2022-3 Three parking laybys closed, initially temporarily then from Sept. ‘23 permanently

2020 COVID lockdown restrictions – Essential travel only, although 1Hr exercise permitted

BEACHY HEAD CHAPLAINCY TEAM

Founded in 2004

Patrolling 4 miles

Day and Night, Every day of the year

28 Chaplains

6 month training period

What We Do

1. Locate and engage with those who have lost hope and are in the darkest of places

2. Suicide intervention

3. Supportive listening

4. Start a dialogue which encourages solutions other than suicide

5. Working with partners to ensure the safety of individuals in crisis

Statistics

- Eastbourne 30%
- Rest of Sussex 27%
- Rest of UK 26%
- From Abroad 2%
- Unknown 16%

2023

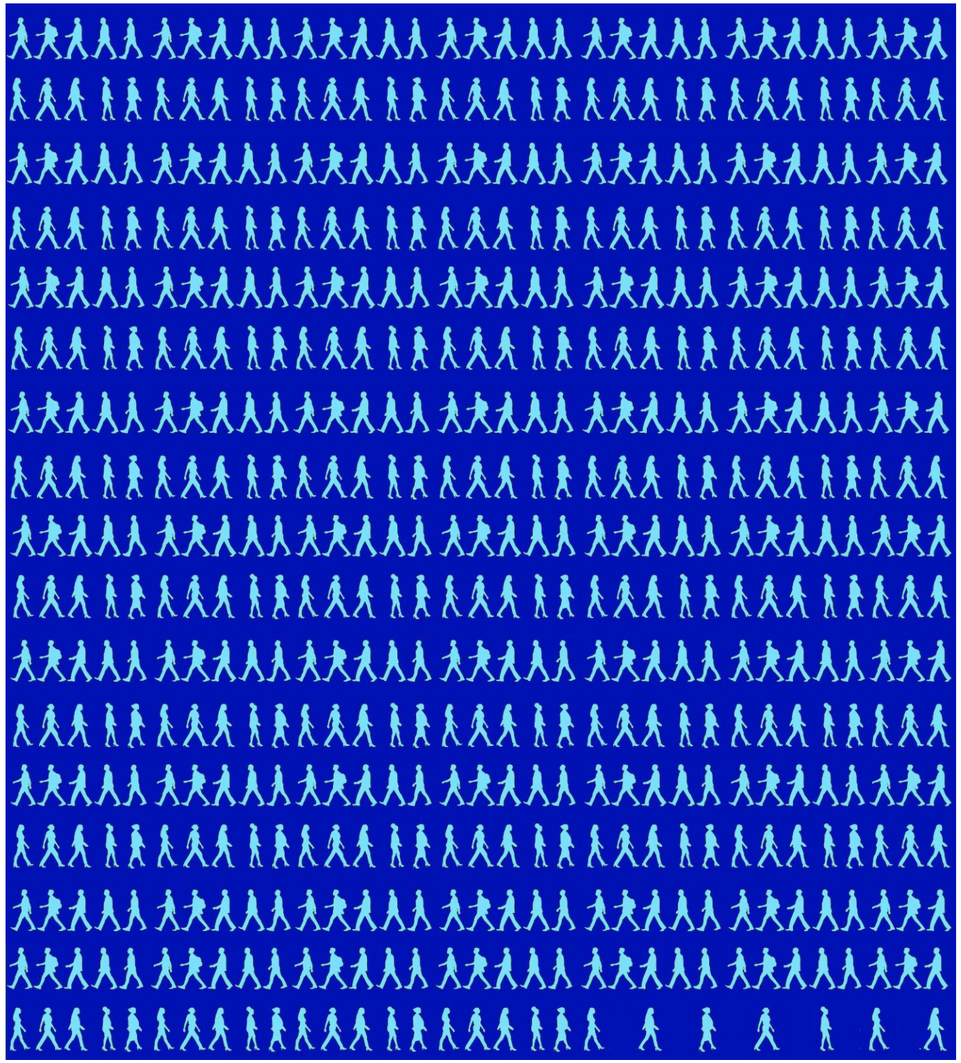
716 Searches – Police / Public

46% male 47% female unknown/other 7%

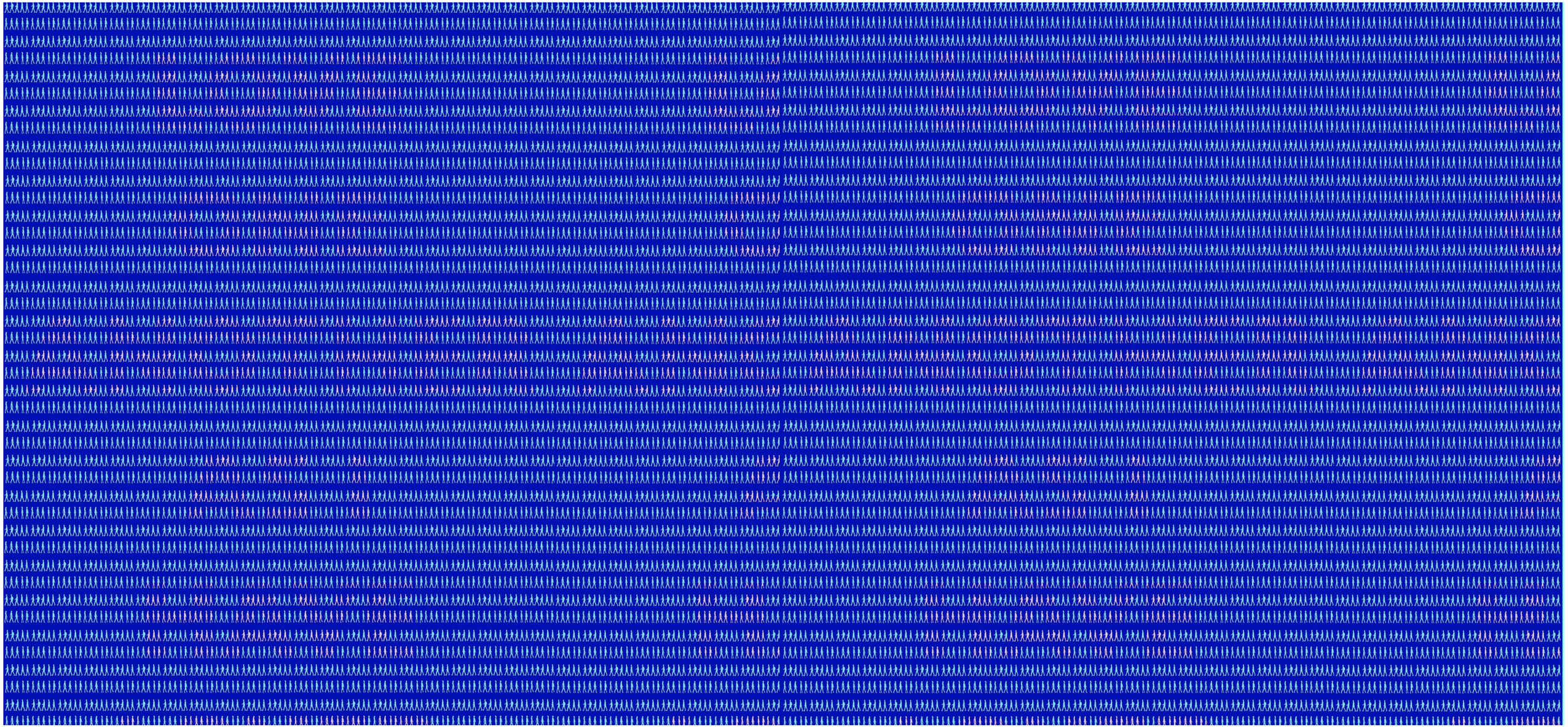
39% age 21-40

81% white

2023 – 527 Engagements



13,000 Interventions since 2004



Hope and Positive Change

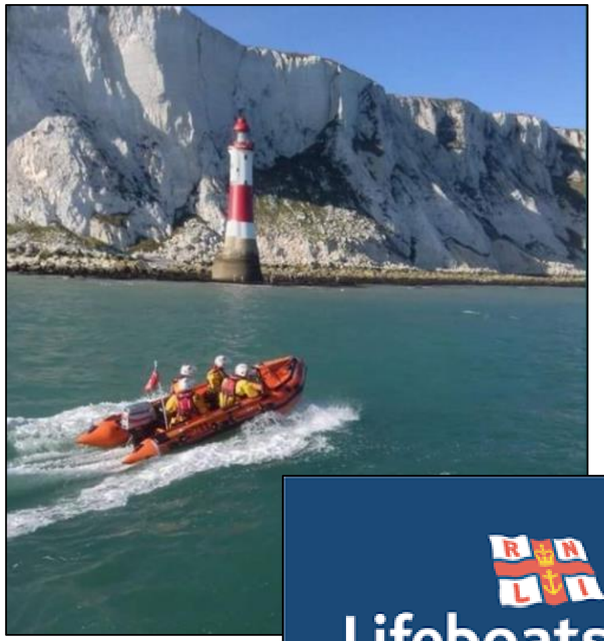
You saved my life. You didn't give up even though I begged you to let me die. You are angels. Everything good in my life right now is down to you guys Thank you isn't enough!

I drove to Beachy Head with the intention of ending my life. I could not see there was any hope. Two Chaplains knocked on my car window and just listened and helped me for hours. I was placed under the crisis mental health team and today I feel so unbelievably blessed to be still alive.

"I was in a very bad place and 3 feet from the edge. Without your kindness and care I would have been a statistic on the local death list. Your support and swift action saves countless lives, mine being one of them, thank you, thank you, thank you."

NHS Mental
Health Street
Triage

The Bigger Picture



Lifeboats

HM Coastguard

Coastguard
Rescue Team

BHC

East Sussex
County Council

Public health

Work with other agencies:

Mental Health Triage

Identify regular attendees

Understand their risk

Put in place a tailored response

Free regular attendees from dangerous pattern of behavior

Ensure resources are available for those most at risk

Work with other agencies:

Move to online incident reporting tool

Capturing real time data showing patterns and trends

Sharing information with Public Health

Closure of Layby's

Taxi Training

Evidence Based Prevention

1. Restrict access to the site and the means of suicide
2. Increase opportunity and capacity for human intervention
3. Increase opportunities for help seeking by the suicidal individual
4. Change the public image of the site

1. Restrict access to the site and the means of suicide

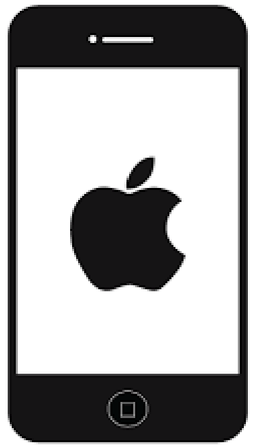
Closures - Barriers - Gateways


HV
BUS
STOP

2. Increase opportunity and capacity for human intervention

Patrols - Increased footfall - Surveillance technologies


BEACHY HEAD CHAPLAINCY TEAM
CRISIS INTERVENTION – SEARCH & RESCUE




ICE CREAM
COOL INSIDE
ICE CREAM
WALL'S
WALL'S
TRAVEL

3. Increase opportunities for help seeking by the suicidal individual

Safe havens - Helpline access - Signage


The
Samaritans
ALWAYS THERE DAY OR NIGHT
TEL:
735555 or 08457 909090


13
THE HAVEN

4. Change the public image of the site

Sensitive reporting - Renaming - Repurposing - Imagery
Removing memorials


BEACHY HEAD
AMBASSADOR

Tragedy Man, 33, drives car off Beachy Head

Tributes after car plunge death off Beachy Head

BY SOL BUCKNER
sol.buckner@jpress.co.uk
@solbuckner2

A MOTHER has told of her devastation and shock after her son was found dead in a car which plunged 450ft down Beachy Head cliffs near Eastbourne.

Sue Curtis, of Freshwater Avenue, is trying to come to terms with the loss of her 33-year-old son Ben who was found last Wednesday (July 17).

Police were called just after 2pm to a report of a car seen over the cliffs.

The car was located on Wednesday after a major search and rescue operation involving coastguard and the fire service.

But the rescue team struggled to reach the wreckage until early Thursday morning because of the position of the car and the incoming tide.

An inquest was opened and adjourned at Eastbourne Coroners Court on Tuesday.

Ben Curtis

Conclusions

Evidence is strong for the preventive measures, but many require resolved effort from multiple professions and organisations

Success have been seen in many examples, but sadly deaths still may occur

There is a balance between implementing such measures and highlighting the issue

There are likely to be a great many “known unknowns” and “unknown unknowns” about particular locations

There is still much work to be done!

Thank You

Your comments, questions and discussion please

Time for a break

Back in 25 minutes

GRASSROOTS
SUICIDE PREVENTION

No one should have to suffer alone and feel like there is no one to listen. Together we can play a part in breaking the stigma and together we can save lives.

Jack

Understanding and preventing suicide

Professor Rory O’Connor
The University of Glasgow

GRASSROOTS
SUICIDE PREVENTION

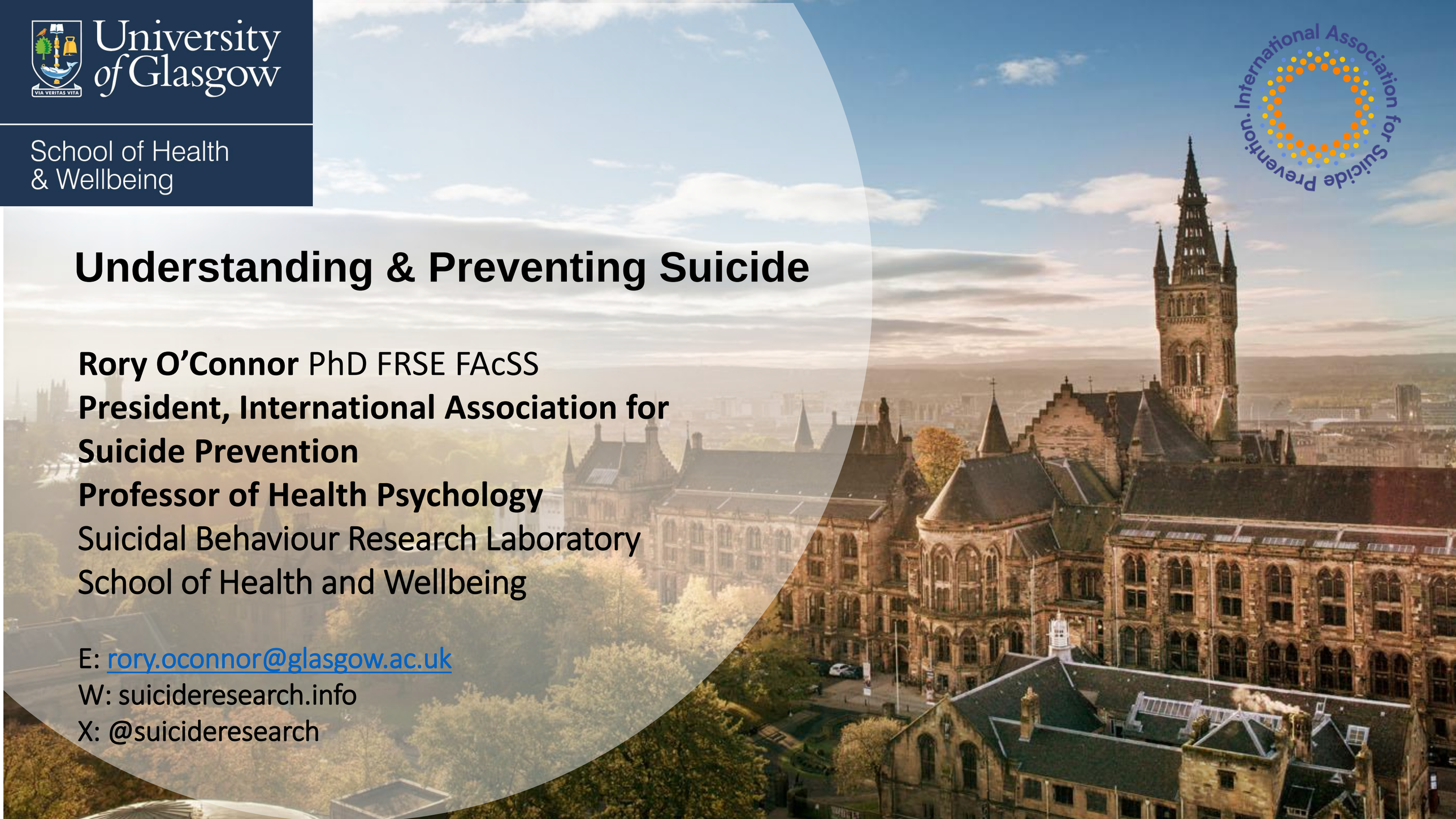
University of Glasgow

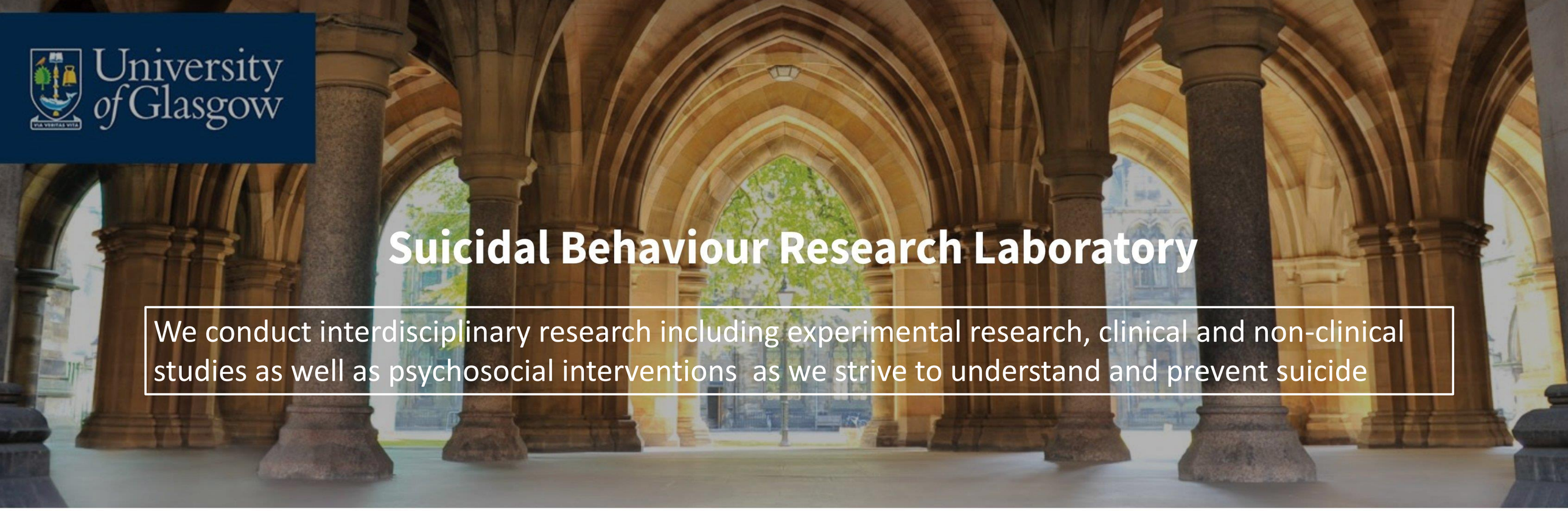
School of Health & Wellbeing

Understanding & Preventing Suicide

Rory O'Connor PhD FRSE FAcSS
President, International Association for Suicide Prevention
Professor of Health Psychology
Suicidal Behaviour Research Laboratory
School of Health and Wellbeing

E: rory.oconnor@glasgow.ac.uk
W: suicideresearch.info
X: @suicideresearch





University of Glasgow

Suicidal Behaviour Research Laboratory

We conduct interdisciplinary research including experimental research, clinical and non-clinical studies as well as psychosocial interventions as we strive to understand and prevent suicide

The Suicidal Behaviour Research Laboratory (SBRL) at the University of Glasgow

UKRI Medical Research Council

Economic and Social Research Council

Medical Research Foundation

Mindstep Foundation

SAMH for Scotland's mental health

NHS SCOTLAND

BARFIL CHARITABLE TRUST

The Scottish Government

CHIEF SCIENTIST OFFICE

Jonathan's Voice Speaking out for mental health

Public Health Scotland

zoetis foundation

NIHR | National Institute for Health Research

MQ Mental health research

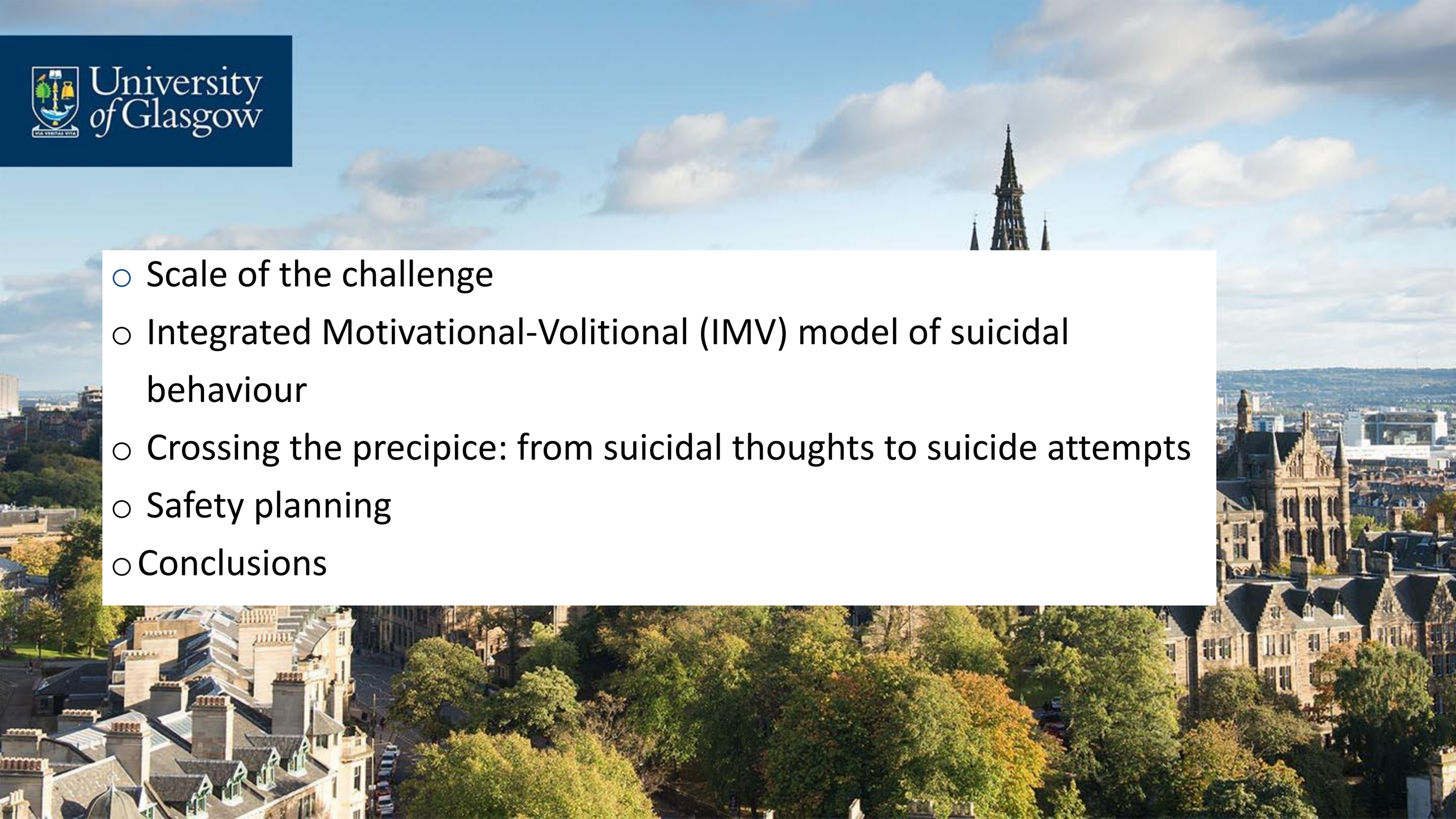
SAMARITANS

CDMRP

ADHD UK

shout 85258

www.suicideresearch.info



- Scale of the challenge
- Integrated Motivational-Volitional (IMV) model of suicidal behaviour
- Crossing the precipice: from suicidal thoughts to suicide attempts
- Safety planning
- Conclusions

University of Glasgow

Increase in suicide rates

News provider of the year

The Guardian

UK

News | Opinion | Sport | Culture | Lifestyle

UK | UK politics | Education | Media | Society | Law | Scotland | **Wales** | Northern Ireland

Suicide rates

Suicide rates in England and Wales reach highest level since 1999

Samaritans charity calls on government to invest in suicide prevention as it has with smoking reduction

Robert Booth *Social affairs correspondent*

Thu 29 Aug 2024 20.23 BST

Share

Three-quarters of the 6,069 people to have killed themselves in 2023 were males. Photograph: FotoDuets/Getty Images/iStockphoto

Ministers have been urged to treat suicide as a public health crisis after the rate at which people killed themselves in England and Wales reached the highest level in more than two decades.

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NEWS

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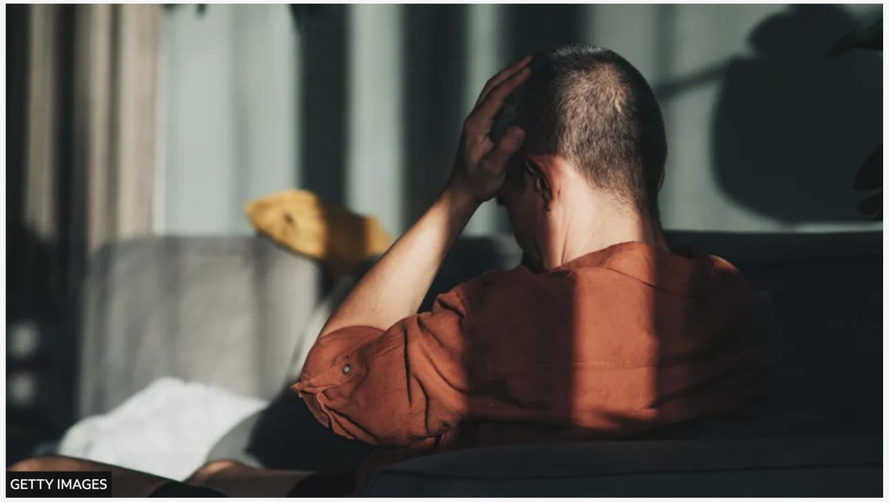
Scotland | Scotland Politics | Scotland Business | Edinburgh, Fife & East | Glasgow & West | Highlands & Islands | NE, C

Alba

Slight rise in Scottish suicide rates, figures show



13 August 2024

The number of probable deaths by suicide increased by 4% in Scotland last year, according to annual figures.

National Records for Scotland records show there was 792 probable cases of people taking their own life in 2023, an increase of 30 on the previous year.

Male suicides increased by 34 to 590, while female suicides decreased by four to 202 deaths in the last year. Suicide in males was over three times as high as the rate for females.

This is the second year in a row there has been an increase after a period of decline in 2020 and 2021.

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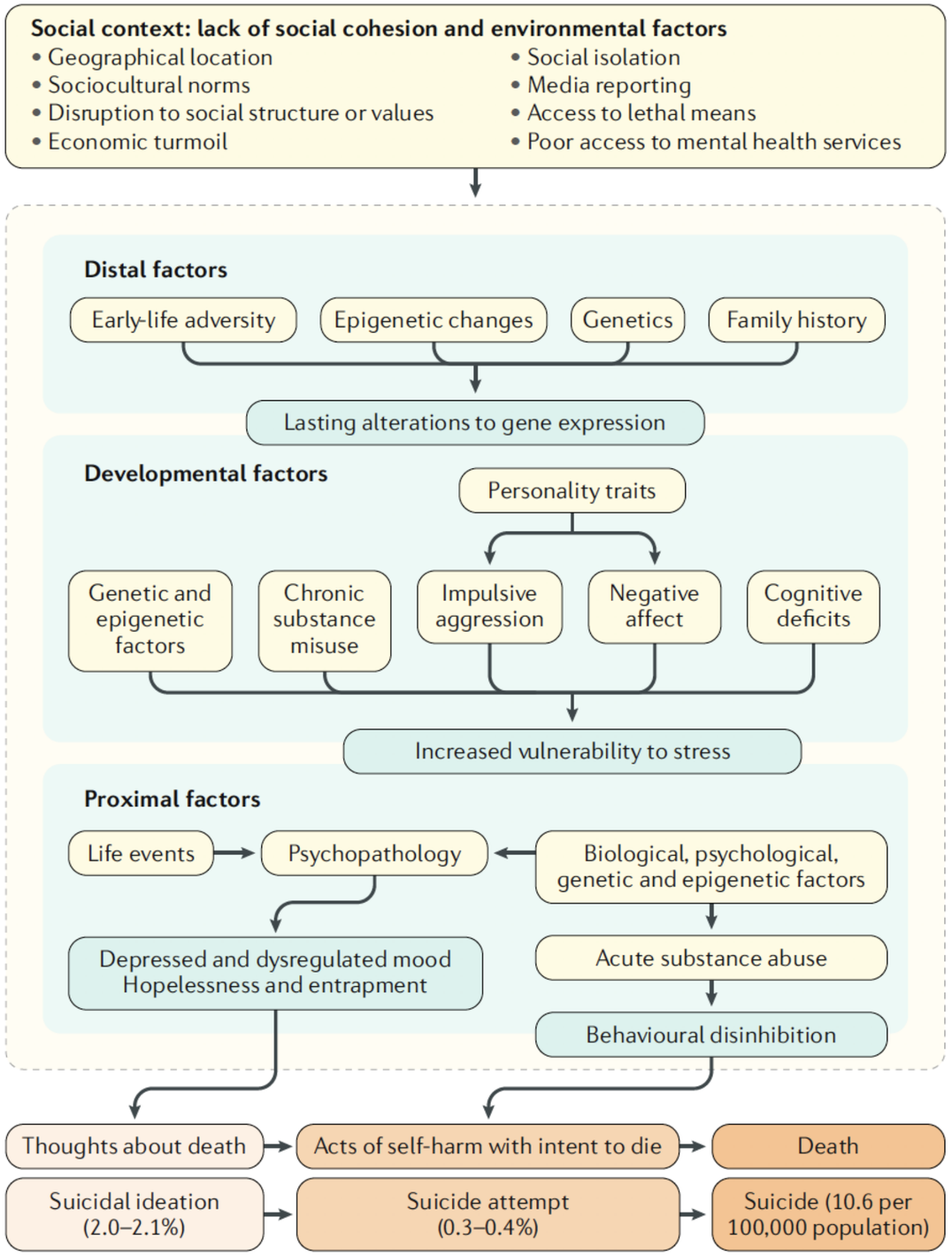

Biopsychosocial model of suicide risk

nature reviews disease primers

Gustavo Turecki[1], David A. Brent[2], David Gunnell[3,4], Rory C. O'Connor[5], Maria A. Oquendo[6], Jane Pirkis[7] and Barbara H. Stanley[8]*

2019

Male Suicide: Gaps in understanding

Photo by Sasha Freemind on Unsplash

Social Science & Medicine 276 (2021) 113831

Review article

A systematic review of suicidal behaviour in men: A narrative synthesis of risk factors

Cara Richardson [a,*], Kathryn A. Robb [b], Rory C. O'Connor [a]

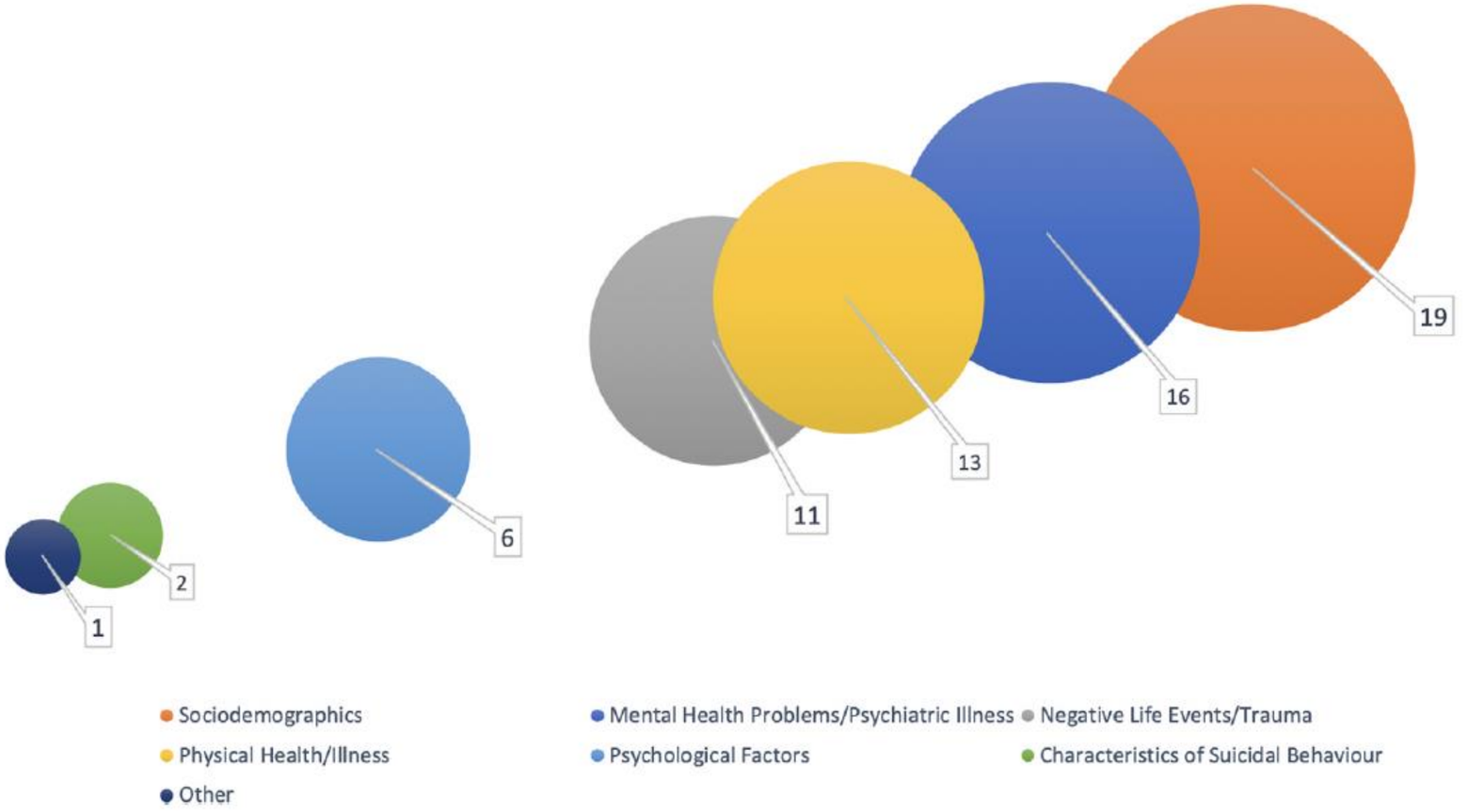

Fig. 2. Bubble chart of number and type of risk factors identified across prospective and retrospective studies.

Male Suicide Risk and Recovery Factors: A Systematic Review and Qualitative Metasynthesis of Two Decades of Research

Psychological Bulletin

2023, Vol. 149, Nos. 7–8, 371–417
https://doi.org/10.1037/bul0000397

Susanna Bennett[1], Kathryn A. Robb[2], Tiago C. Zortea[1, 3], Adele Dickson[4], Cara Richardson[1], and Rory C. O'Connor[1]

Figure 3

3 "D" Model of Masculine Norms and Male Suicide Risk

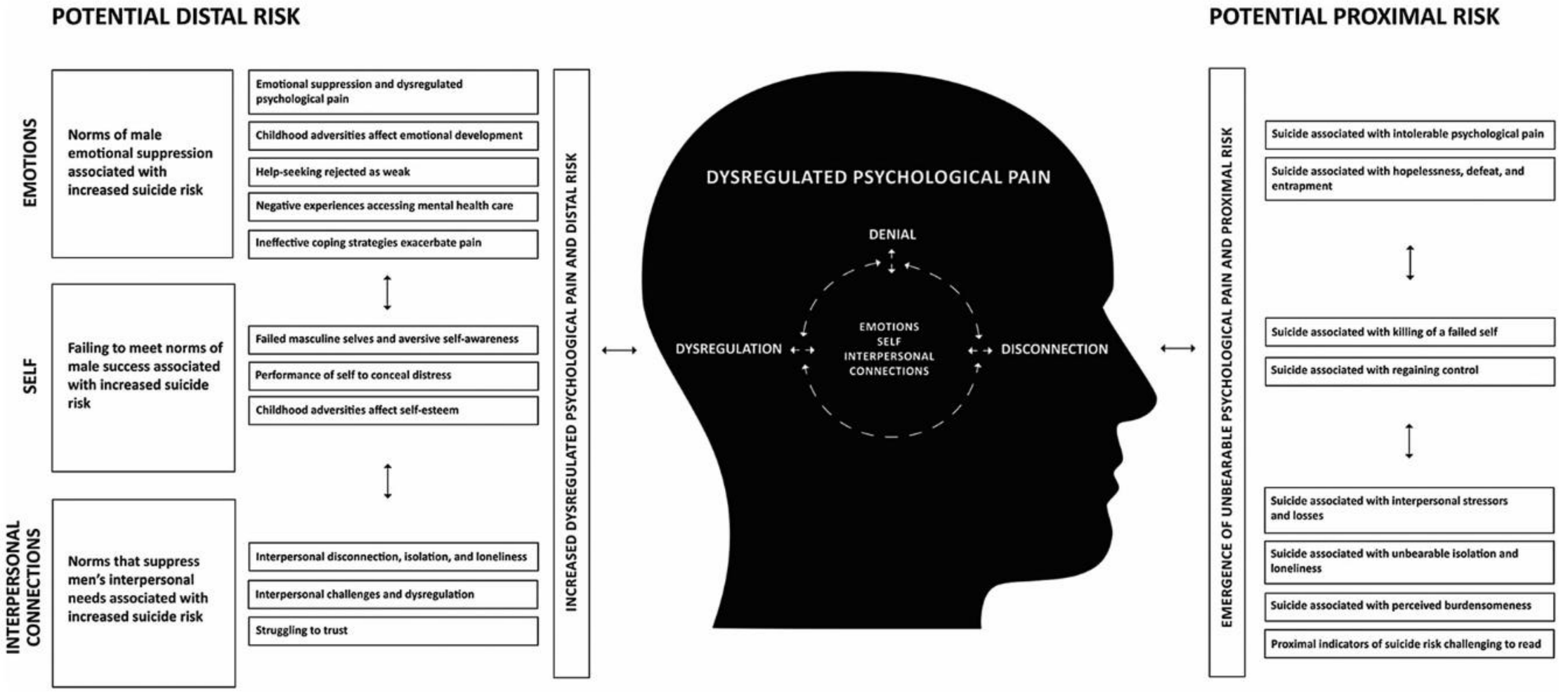

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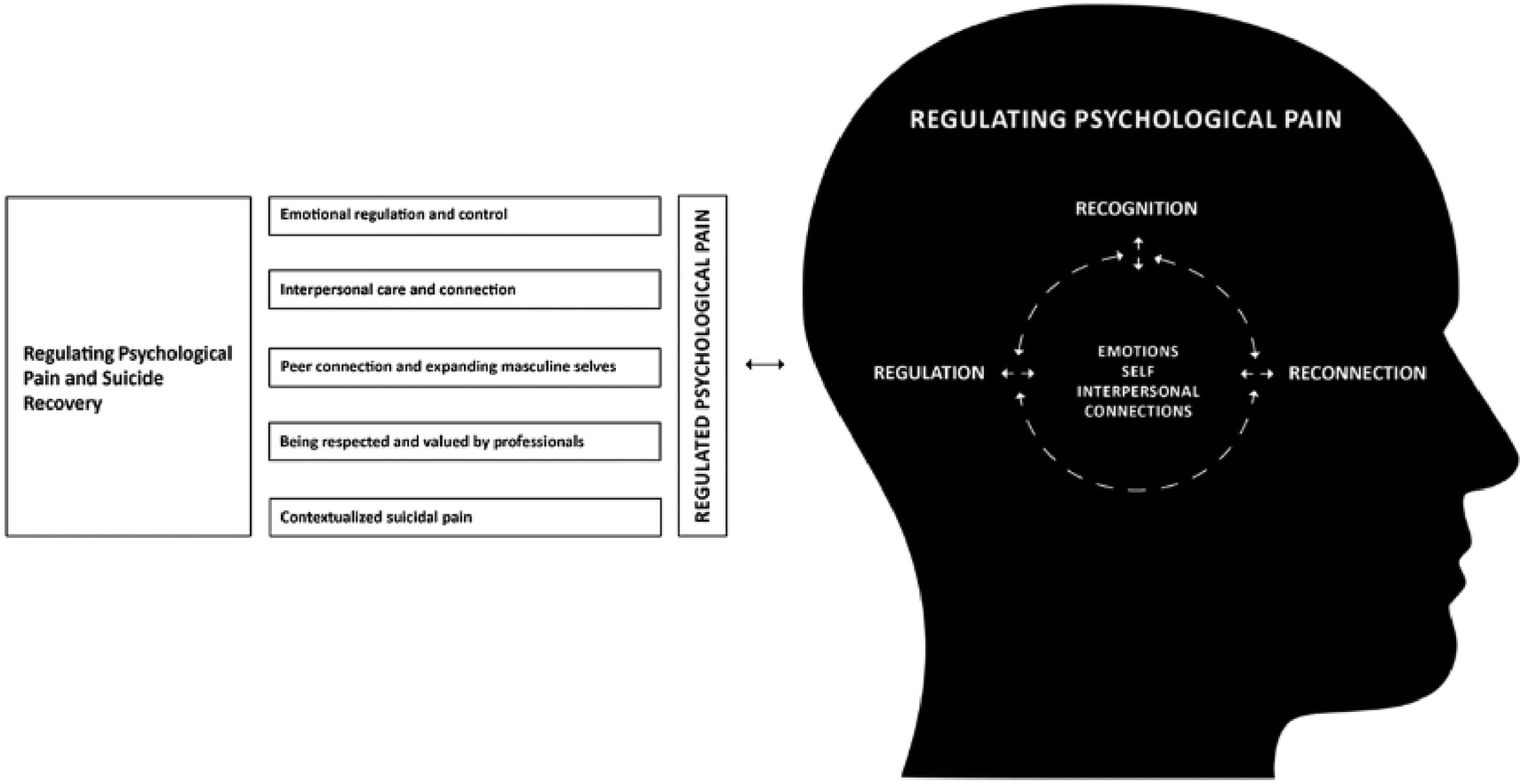
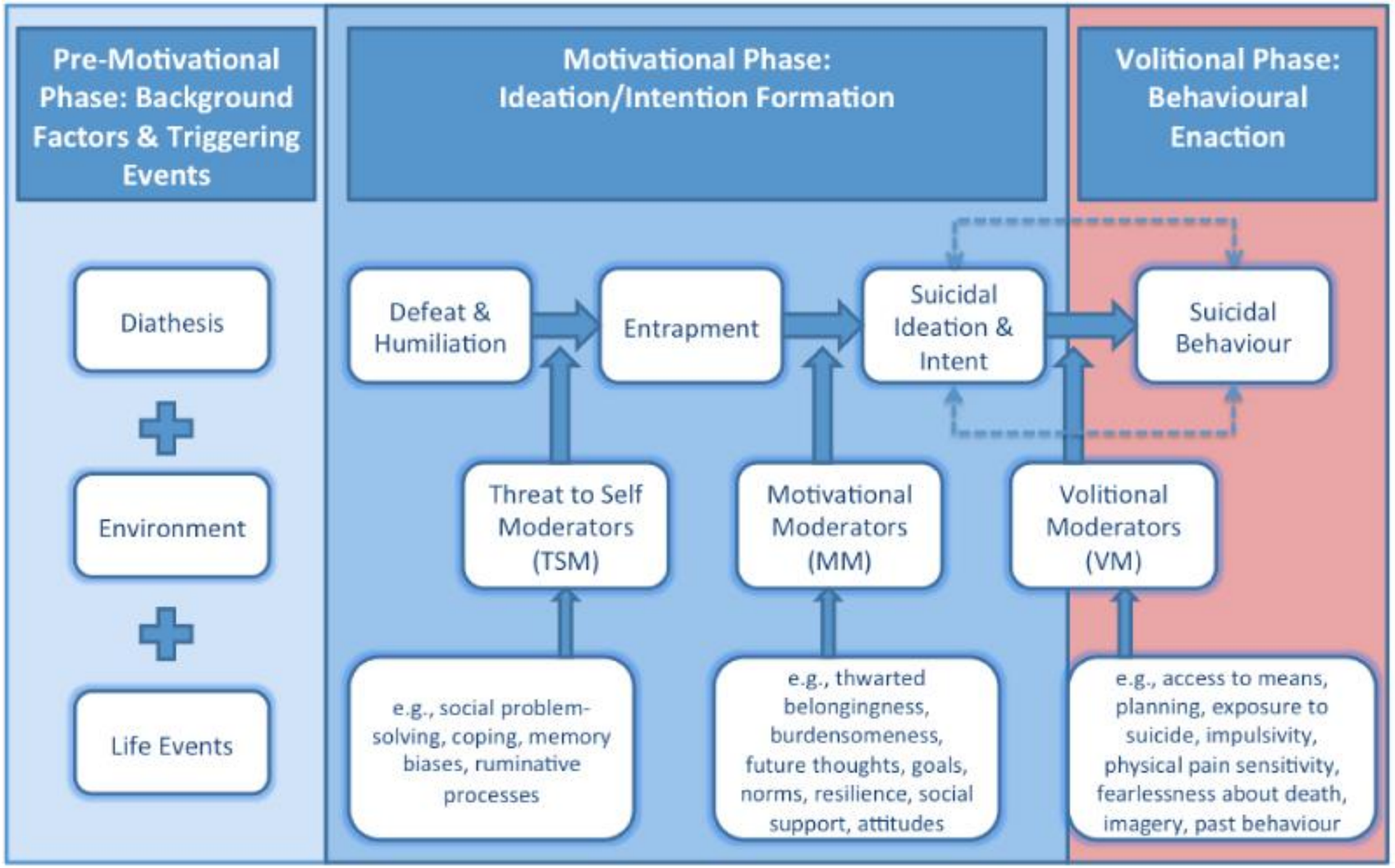
Figure 4

3 "R" Model of Male Suicide Recovery



Integrated motivational-volitional (IMV) model of suicidal behaviour



O'Connor, R.C., Kirtley, O.J. (2018). The Integrated Motivational-Volitional Model of Suicidal Behaviour *Philosophical Transactions of the Royal Society B.* 373: 20170268

HEALTH PSYCHOLOGY REVIEW
https://doi.org/10.1080/17437199.2024.2336013

Routledge
Taylor & Francis Group

2024

REVIEW ARTICLE

OPEN ACCESS Check for updates

A systematic review of the studies testing the integrated motivational-volitional model of suicidal behaviour

Kenvil Souza[a]*, Edward M. Sosu[b], Scott Thomson[a] and Susan Rasmussen[a]

Findings from 100 studies (138,365 participants) were narratively synthesised

Studies empirically testing at least one pathway within the IMV model

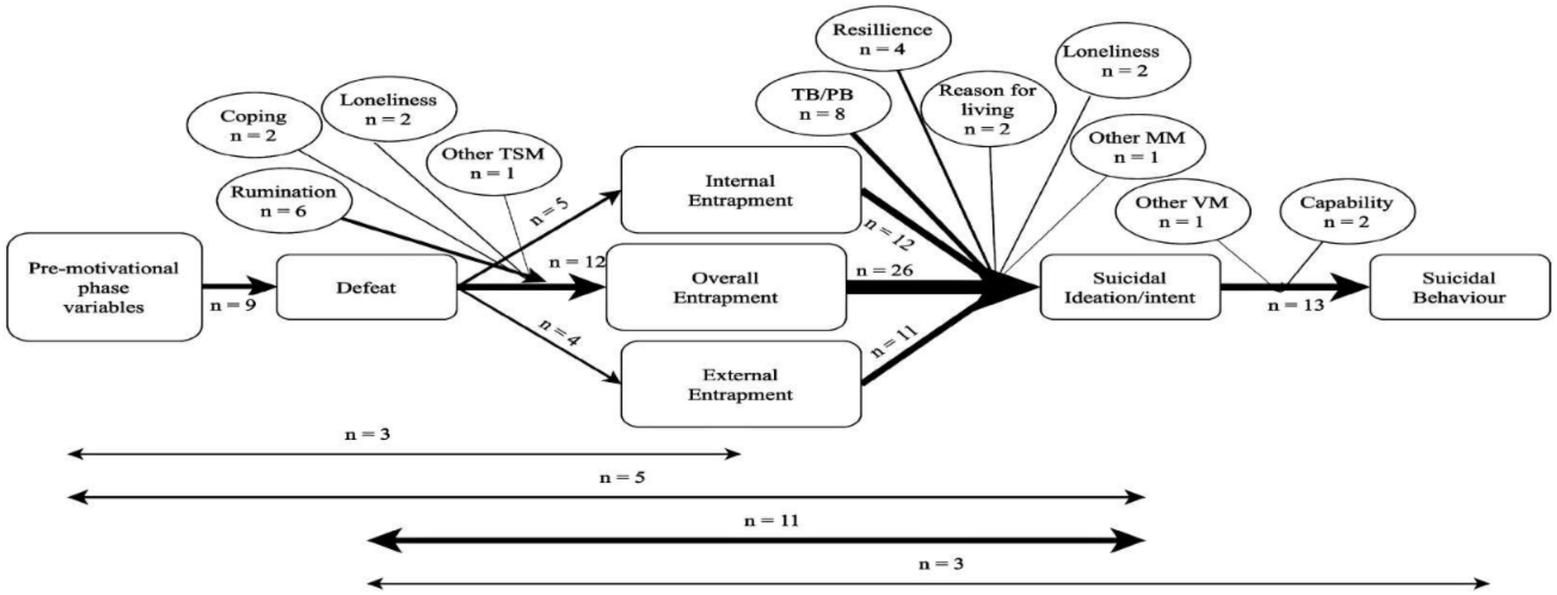


Figure 3. Frequency of IMV model pathways tested in included studies. Note. TSM = Threat-to-self moderators, TB = Thwarted Belongingness, PB = Perceived Burdensomeness, MM = Motivational moderators, VM = Volitional Moderators. This figure demonstrates the pathways in the IMV model that were investigated within the included studies. The thickness of the arrows represents the number of studies that tested the relevant association. Similarly, the arrows at the bottom represent the number of studies that tested pathways using mediation models. N provides the actual number of studies testing the pathway.

ADHD & Suicide Risk

"I feel like if I didn't have ADHD…maybe I wouldn't have formed like this and I wouldn't feel this way. Maybe I could fit in with other people instead of being different and sometimes I would just think that my ADHD was a really big, major reason, like maybe it's not the cause of why I was suicidal but because of my ADHD, it led to the cause and then I became suicidal. There were a few attempts where I tried to like end my life and, because I was isolated…and I felt, so that, that's like, that's, that's a part of the reason for maybe being suicidal…"

Rosie, 18 years

Cleare, Belkadi, & O'Connor (in prep)

“Am I really alive?”: Understanding the role of homophobia, biphobia and transphobia in young LGBT+ people’s suicidal distress

Hazel Marzetti [a,b,*], Lisa McDaid [b,c], Rory O’Connor [d]

2022

Social Science & Medicine an international journal

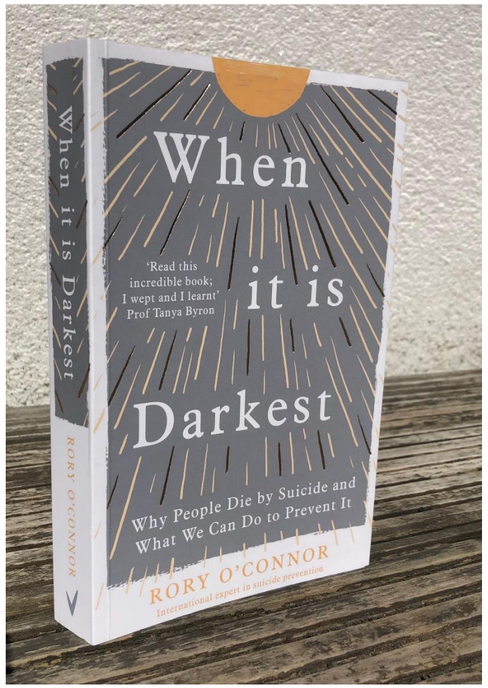
Understanding suicide as a response

‘Queer entrapment’ and suicide as escape:

in which queerphobic conflict about their LGBT+ identity was perceived to be irresolvable and from which suicide was seen as an escape.

Lily (24; she/her): “there have been times when I’ve just been like, oh, if I just ended my life it would just stop everything [...] No one would have to deal with it, no one would have to be like, “oh, we’ve got a gay daughter” – no one would have to deal with it, it would just stop all the problems. I felt like that was the only way out of it all was just to like disappear.”

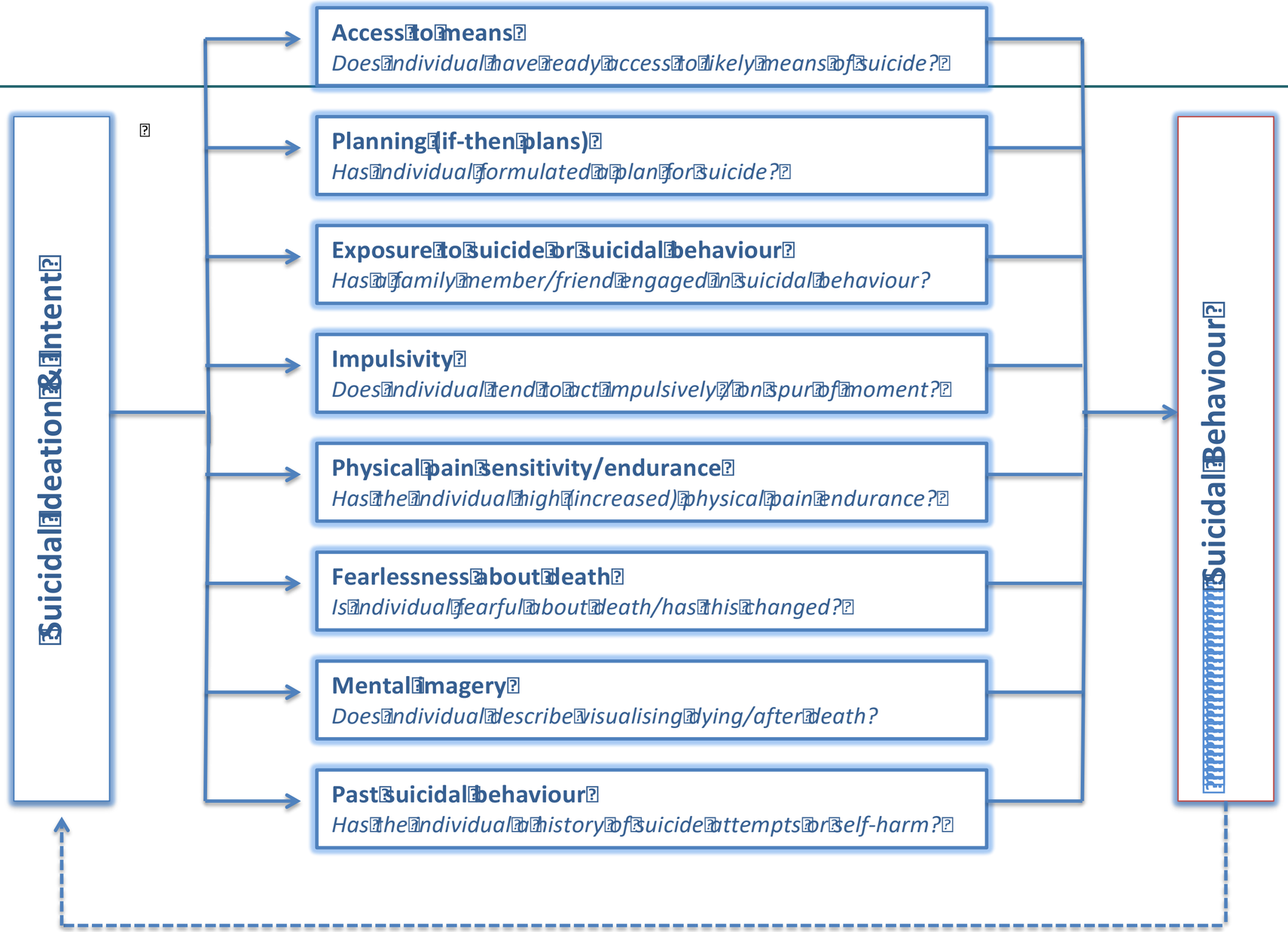
Crossing the Precipice: From Thoughts of Suicide to Suicidal Behaviour



I never thought he'd do it. A few weeks before his death, he had told me that he had thoughts about being dead, but I was too scared to ask him directly whether he would kill himself. I haven't stopped asking myself why I didn't ask him. Not a day passes when I don't torment myself with this question. When I look back on it now, I just didn't think he was the type of person who would kill himself. I know how ridiculous that sounds, but he was just always so full of life.

O'Connor (2021). *When It Is Darkest*

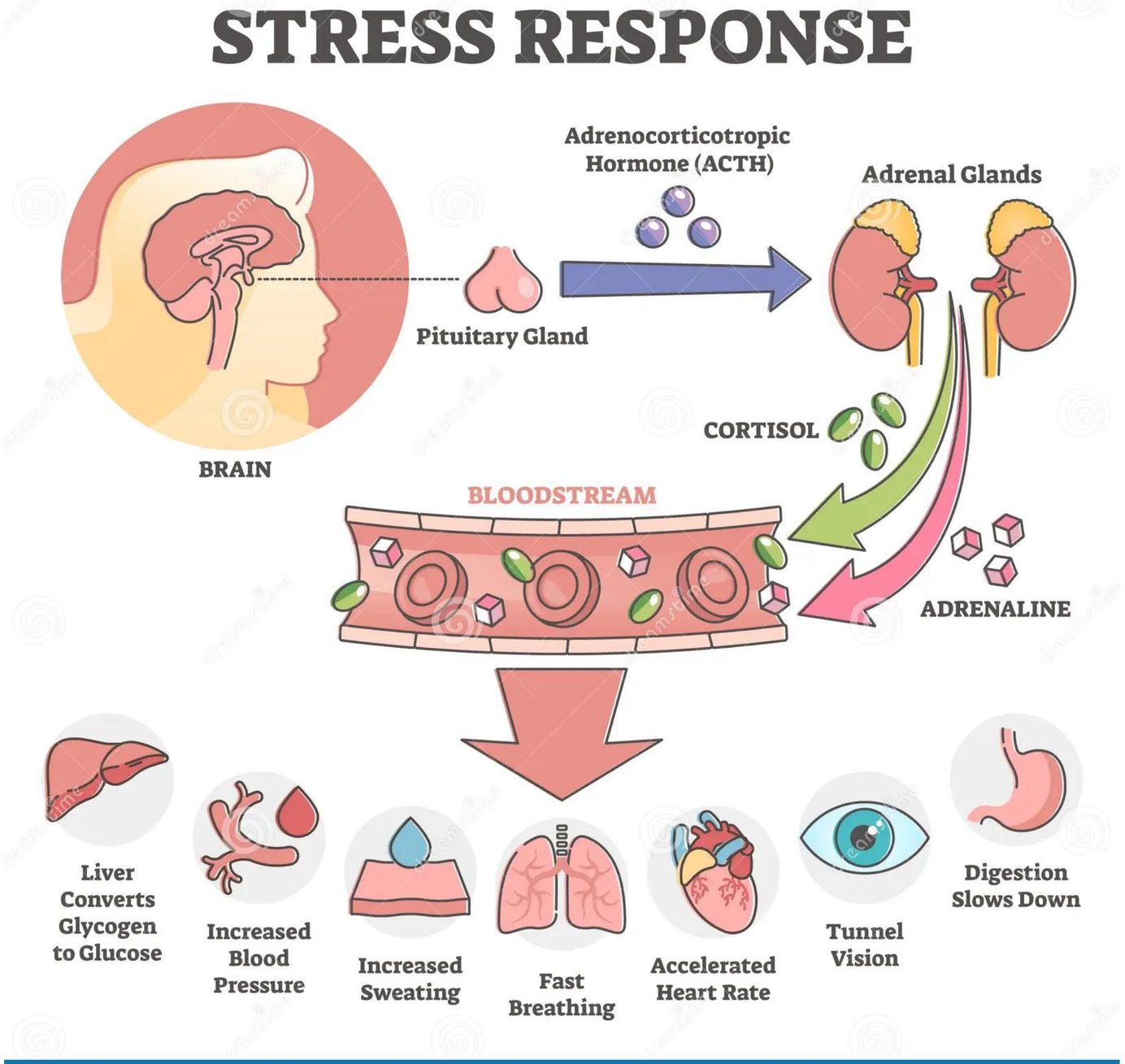
IMV model: From Suicidal Thoughts to Suicidal Behaviour: Volitional Factors



O'Connor, R.C., Kirtley, O.J. (2018). The Integrated Motivational-Volitional Model of Suicidal Behaviour *Philosophical Transactions of the Royal Society B.* 373: 20170268

University of Glasgow

Cortisol and the Stress Response



Contents lists available at ScienceDirect

Psychoneuroendocrinology

journal homepage: www.elsevier.com/locate/psyneuen

Cortisol reactivity and suicidal behavior: Investigating the role of hypothalamic-pituitary-adrenal axis responses to stress in suicide

Daryl B. O'Connor (PhD)[a,*], Jessica A. Green (MSc)[a], Eamonn Ferguson (PhD)[b], Ronan E. O'Carroll (PhD)[c], Rory C. O'Connor (PhD)[d]

[a] School of Psychology, University of Leeds, Leeds UK
[b] School of Psychology, University of Nottingham, Nottingham, UK
[c] Division of Psychology, University of Stirling, Stirling, UK
[d] Suicidal Behavior Research Laboratory, Institute of Health & Wellbeing, University of Glasgow, Glasgow, UK

ARTICLE INFO

Article history:
Received 23 April 2016
Received in revised form 19 October 2016
Accepted 21 October 2016

Keywords:
Cortisol reactivity
Chronic stress
HPA axis
Self-harm
Allostatic load

ABSTRACT

Every 40 s a person dies by suicide somewhere in the world. The causes of suicidal behavior are not fully understood. Dysregulated hypothalamic-pituitary-adrenal (HPA) axis activity, as measured by cortisol levels, is one potential risk factor. The current study aimed to investigate whether cortisol reactivity to a laboratory stress task differentiated individuals who had previously made a suicide attempt from those who had thought about suicide (suicide ideators) and control participants. One hundred and sixty participants were recruited to a previous attempt, a suicidal ideation or a control group. Participants completed background questionnaires before completing the Maastricht Acute Stress Test (MAST). Cortisol levels were assessed throughout the stress task. Measures of suicide behavior were measured at baseline, 1 month and 6 month follow-up. Participants who had made a previous suicide attempt exhibited significantly lower aggregate cortisol levels during the MAST compared to participants in the control group; suicide ideators were intermediate to both groups. This effect, however, was driven by participants who made an attempt within the past year, and to some degree by those with a family history of attempt. Participants who made a suicide attempt and had a family history of suicide exhibited the lowest levels of cortisol in response to stress. Finally, lower levels of cortisol in response to the MAST were associated with higher levels of suicidal ideation at 1-month follow-up in the suicide attempter group. These results are consistent with other findings indicating that blunted HPA axis activity is associated with some forms of suicidal behavior. The challenge for researchers is to elucidate the precise causal mechanisms linking stress, cortisol and suicide risk.

Twin Collaboration

Those who have attempted suicide display blunted cortisol response during the MAST

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[a] School of Psychology, University of Leeds, Leeds UK
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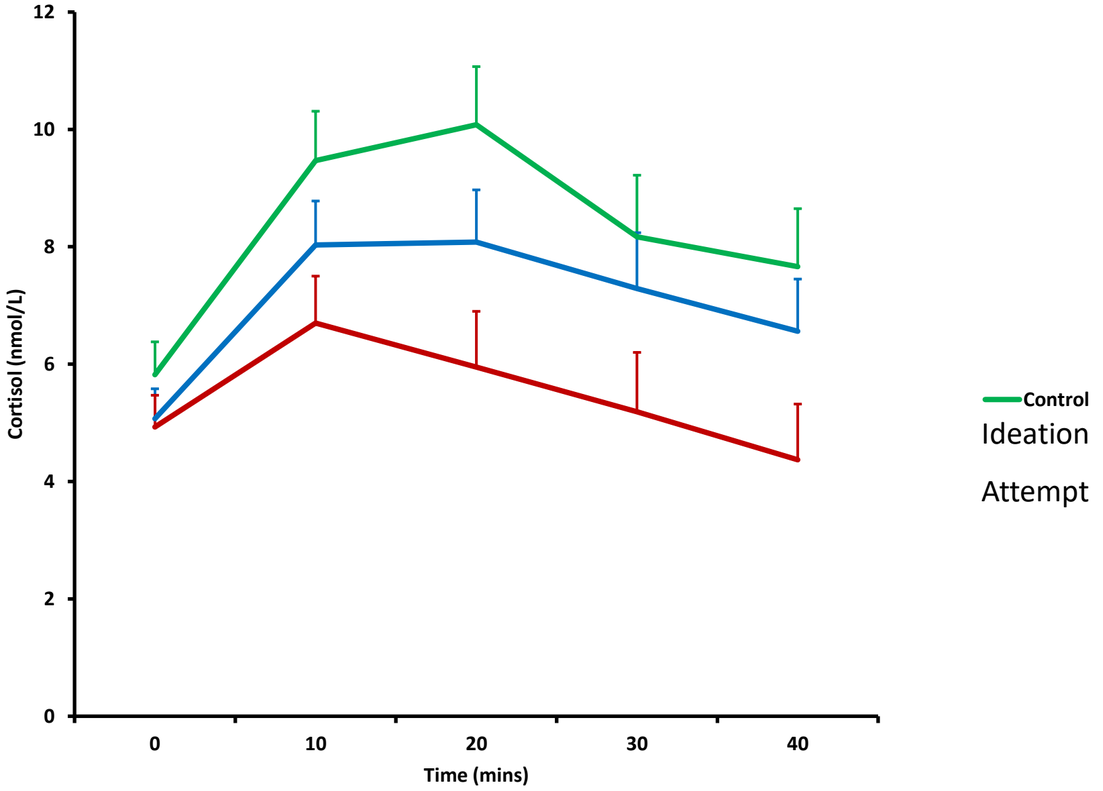
ABSTRACT

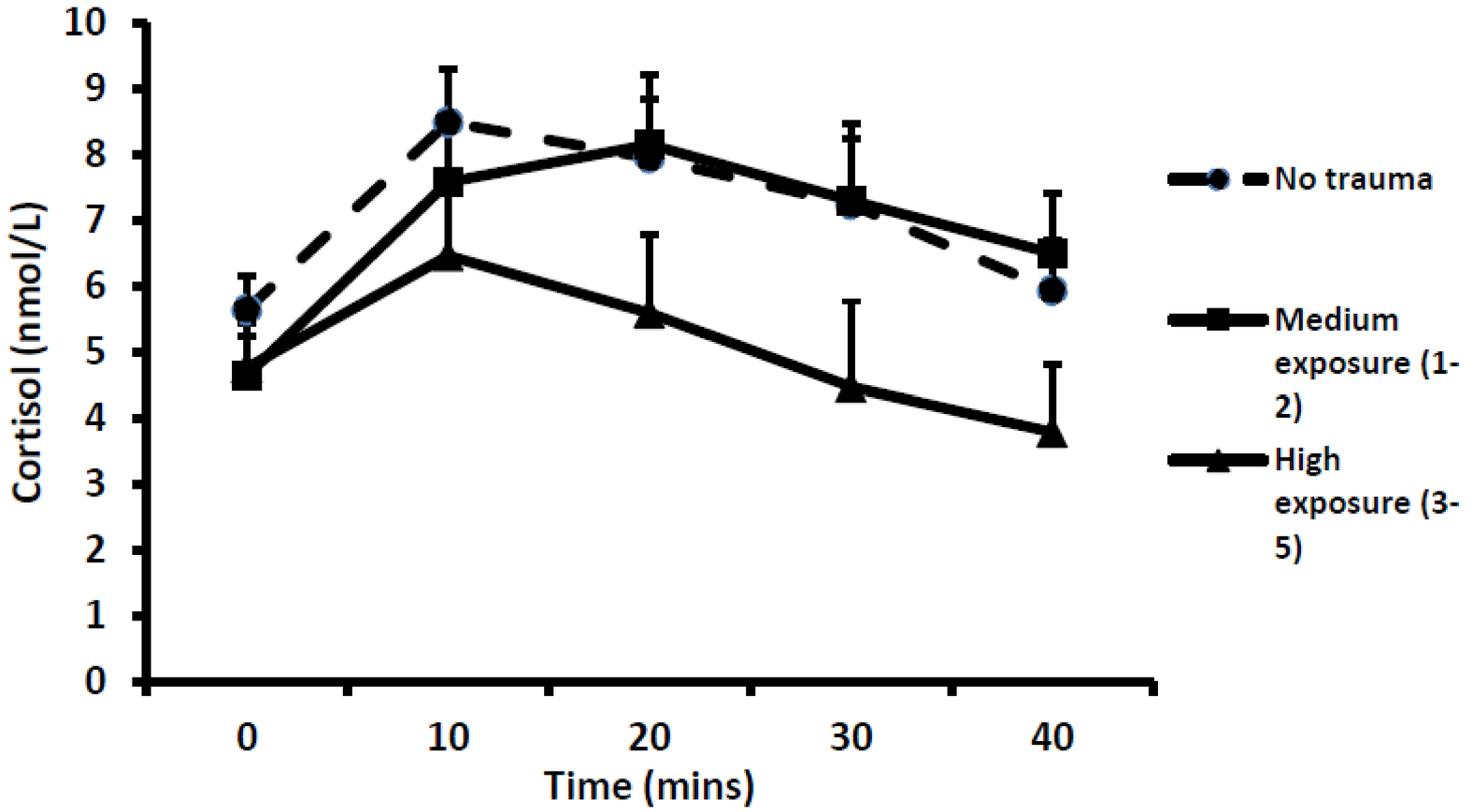
Every 40 s a person dies by suicide somewhere in the world. The causes of suicidal behavior are not fully understood. Dysregulated hypothalamic-pituitary-adrenal (HPA) axis activity, as measured by cortisol levels, is one potential risk factor. The current study aimed to investigate whether cortisol reactivity to a laboratory stress task differentiated individuals who had previously made a suicide attempt from those who had thought about suicide (suicide ideators) and control participants. One hundred and sixty participants were recruited to a previous attempt, a suicidal ideation or a control group. Participants completed background questionnaires before completing the Maastricht Acute Stress Test (MAST). Cortisol levels were assessed throughout the stress task. Measures of suicide behavior were measured at baseline, 1 month and 6 month follow-up. Participants who had made a previous suicide attempt exhibited significantly lower aggregate cortisol levels during the MAST compared to participants in the control group; suicide ideators were intermediate to both groups. This effect, however, was driven by participants who made an attempt within the past year, and to some degree by those with a family history of attempt. Participants who made a suicide attempt and had a family history of suicide exhibited the lowest levels of cortisol in response to stress. Finally, lower levels of cortisol in response to the MAST were associated with higher levels of suicidal ideation at 1-month follow-up in the suicide attempter group. These results are consistent with other findings indicating that blunted HPA axis activity is associated with some forms of suicidal behavior. The challenge for researchers is to elucidate the precise causal mechanisms linking stress, cortisol and suicide risk.



Main effect of group for cortisol levels, p=0.02; AUCg, p=0.02, AUCi, p=0.04

Note: All analyses controlled for age, BMI, medication usage, time of day, smoking, & gender

Effects of childhood trauma on cortisol reactivity to stress (AUCg)

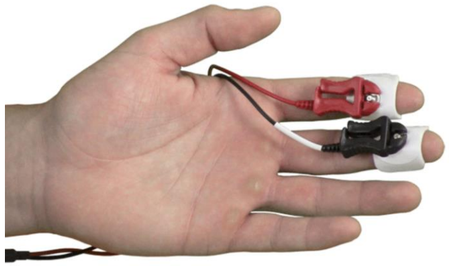


O'Connor, D., Green, J., Ferguson, E., O'Carroll, O'Connor, R. (2018) *Psychoneuroendocrinology*

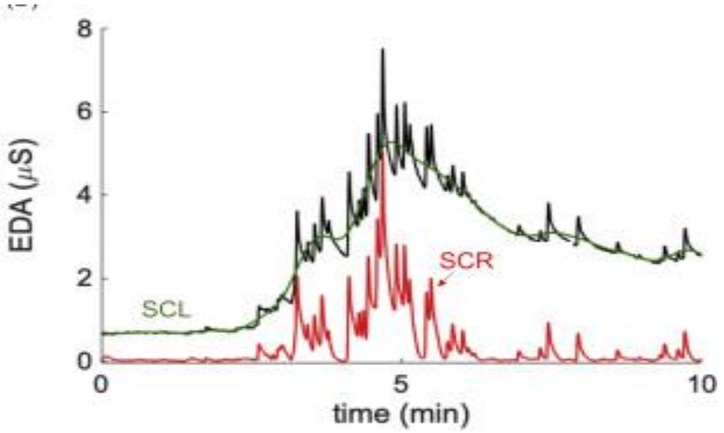
The EMERGE Study

Does electrodermal activity (EDA) act as a volitional moderator facilitating transition from thoughts of self-harm to self-harm acts?

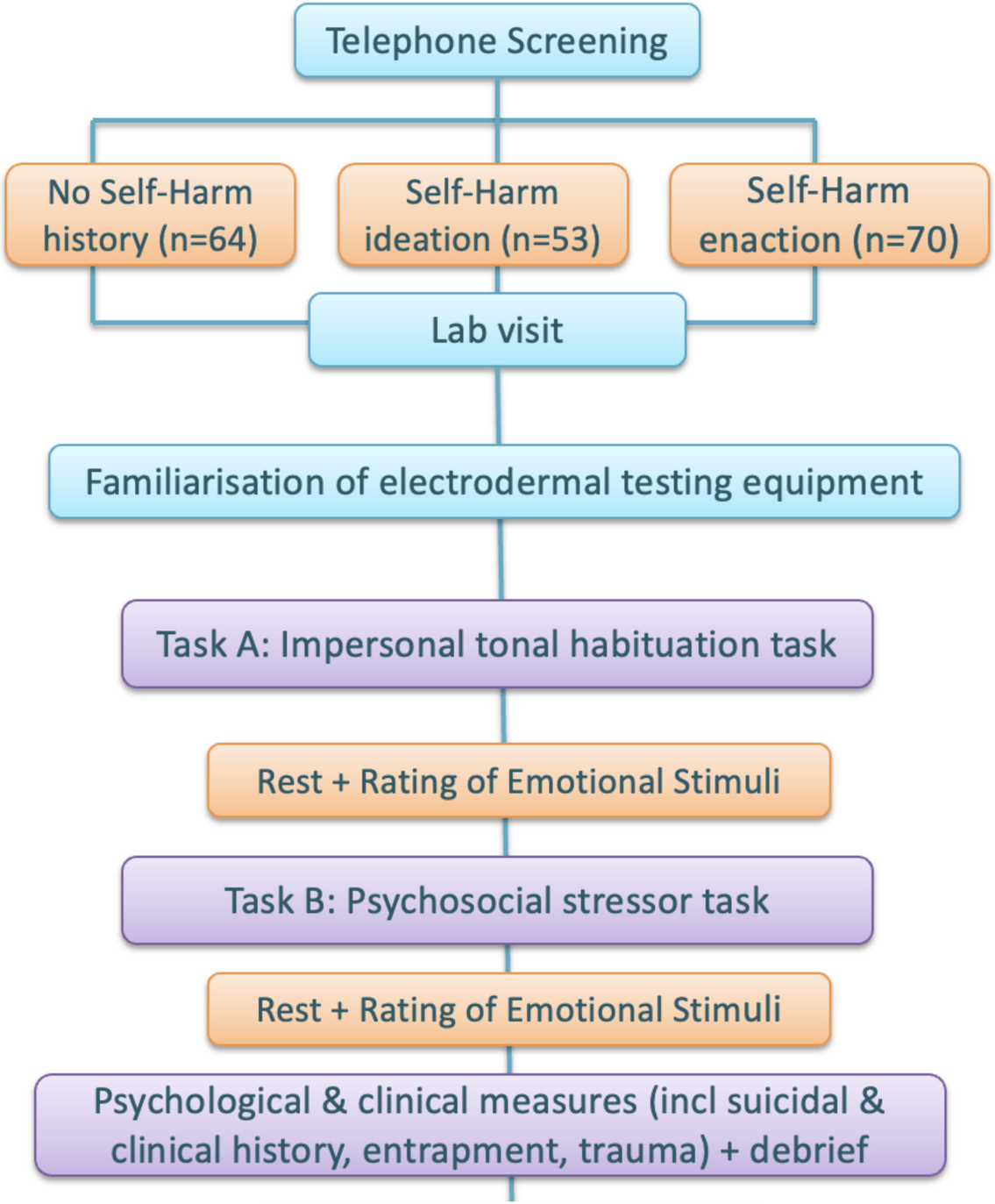
- EDA is a robust and non-invasive marker of physiological arousal linked to emotional processing, measuring autonomic activation of sweat glands in response to stimuli.



- EDA consists of two components:
  - Tonic background measurement of fluctuations in skin conductance level (SCL)
  - Phasic spike in skin conductance response (SCR) within 1-4 of stimuli presentation



Wetherall, Cleare, Belkadi, Etherson, Loney, Mathew, Munro, Townsend, Nock, Ferguson, & O'Connor (under review)



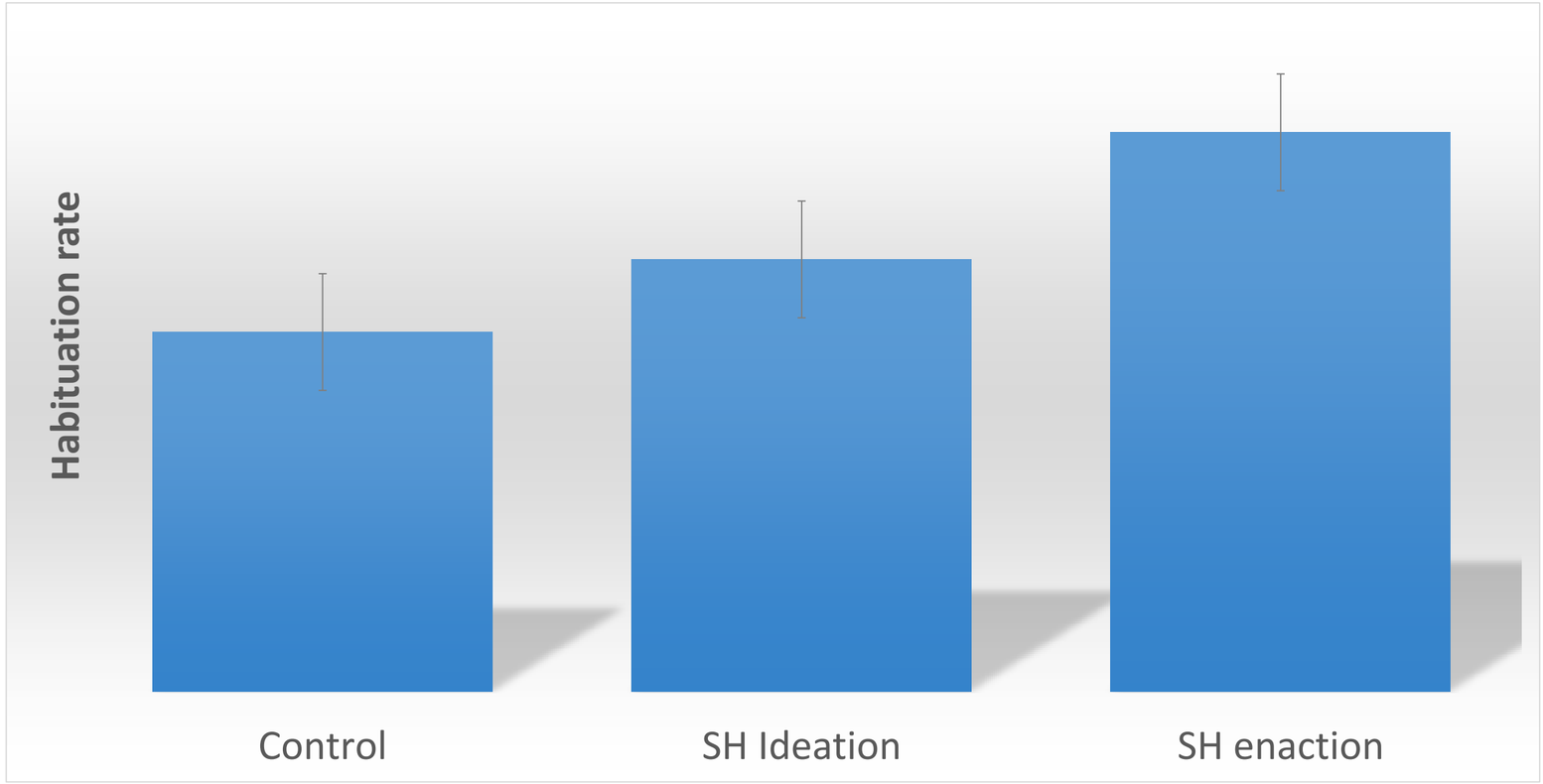
Does EDA distinguish young people (age 16-25) who have thoughts of self-harm ideation vs those who have self-harmed?

- Study included 2 tasks:
  - **Tones task**: habituation to repeated audio stimuli
  - **Psychosocial stress task:** completing the Maastricht Acute Stress Test (MAST)
- Findings from the Tones and Stress Tasks – under review so please don't share

Medical Research Foundation

What did we find?

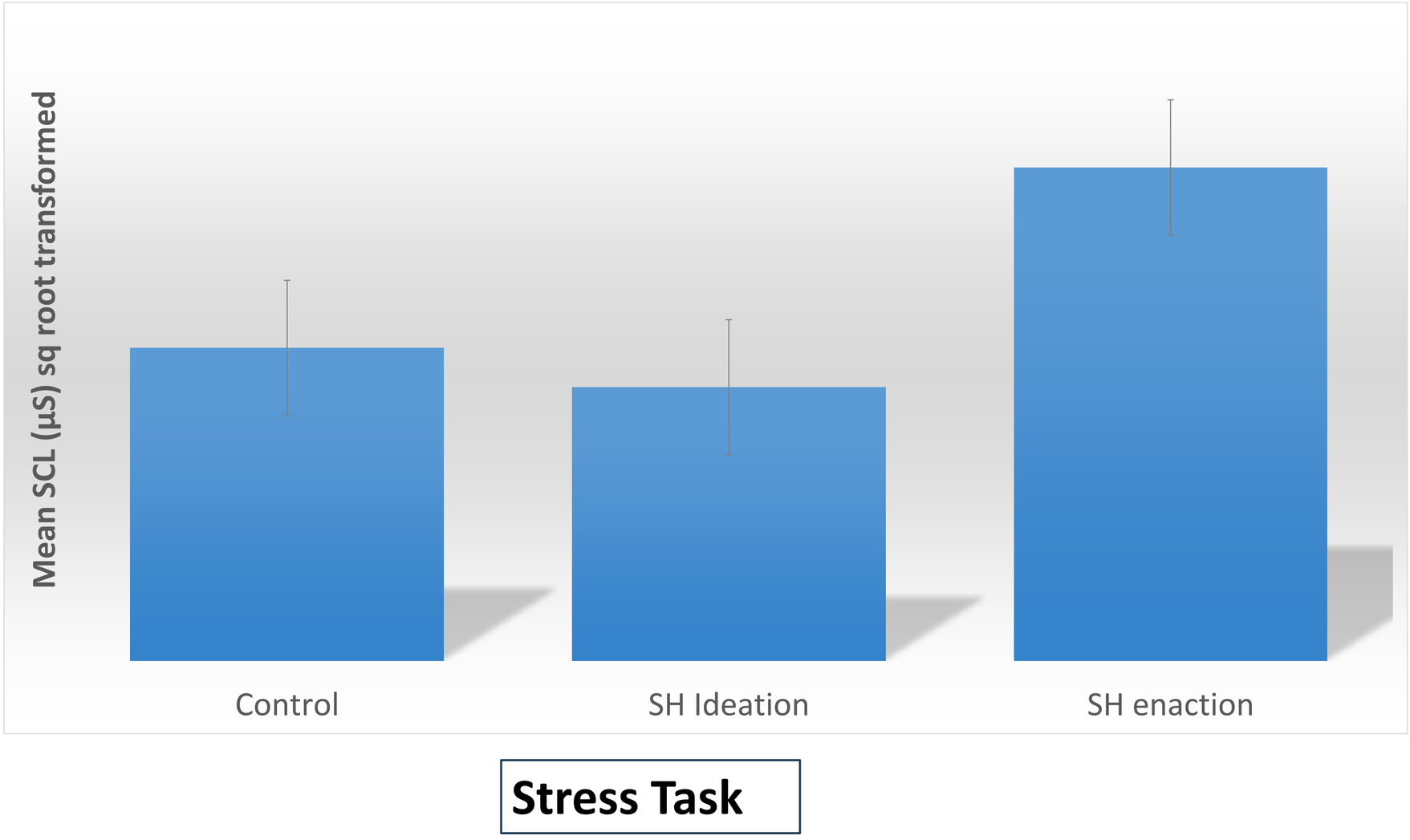
- GLM analysis controlling for age and gender suggested that the self-harm (SH) enaction group habituated significantly slower
- Young people who self-harm are **hyper-reactive** to impersonal stimuli such as tones



Tones Task

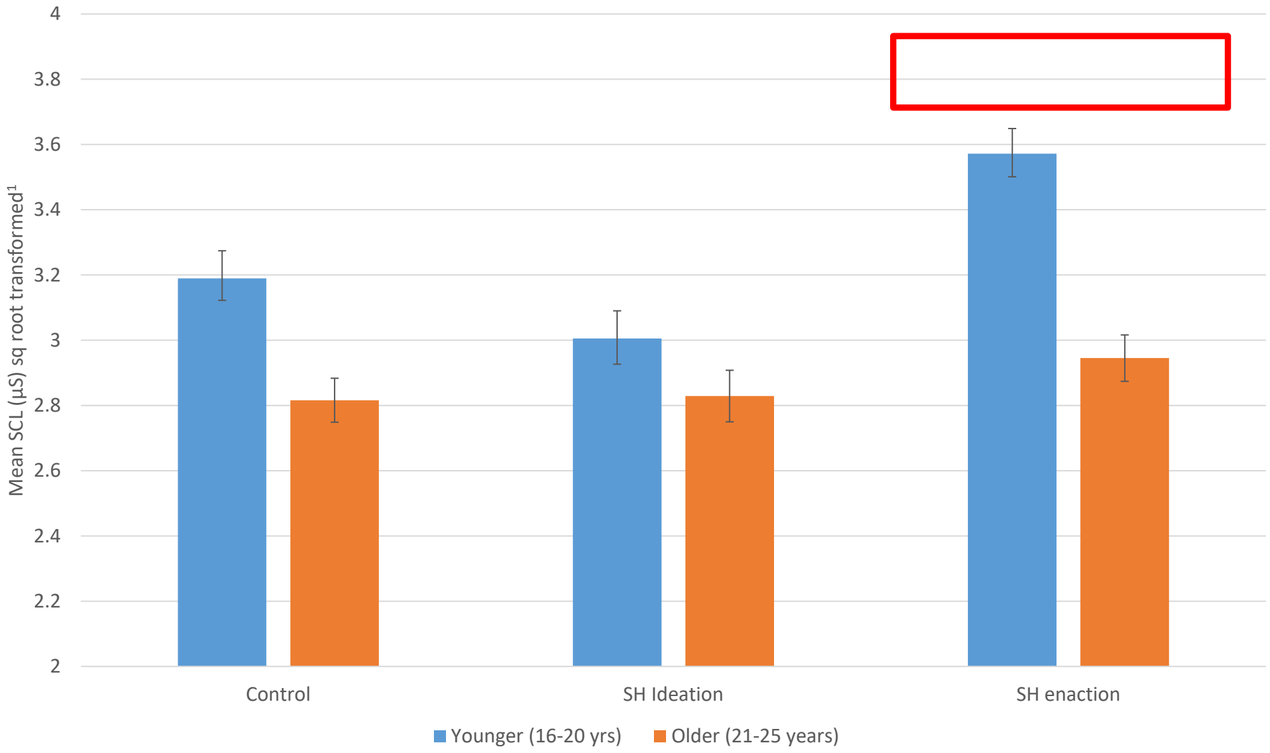
I. What did we find?: Overall

- Group differences in mean SCL during the stress task ($p < 0.001$)
- The self-harm (SH) enaction group had higher mean SCL compared to both the control ($p = 0.01$) and SH ideation groups ($p = 0.007$)



II. What did we find? Age effects

Analysis indicated age differences in SCL during the stress task: younger (16-20 yrs) group had higher mean SCL compared to the older (21-25 yrs) group



- Group x Age interaction significant.
- Younger participants in the self-harm enaction group exhibited higher SCL than the older participants, compared to the self-harm ideation group
- **EDA: potential biomarker/volitional factor**
- **Wear & Tear hypothesis, hyper-sensitivity in adolescence**

Lancet Commission on self-harm: launched on 10th October 2024

The *Lancet* Commission on self-harm

Paul Moran, Amy Chandler†, Pat Dudgeon‡, Olivia J Kirtley§, Duleeka Knipe¶, Jane Pirkis||, Mark Sinyor||, Rosie Allister, Jeffrey Ansloos, Melanie A Ball, Lai Fong Chan, Leilani Darwin, Kate L Derry, Keith Hawton, Veronica Heney, Sarah Hetrick, Ang Li, Daiane B Machado, Emma McAllister, David McDaid, Ishita Mehra, Thomas Niederkrotenthaler, Matthew K Nock, Victoria M O'Keefe, Maria A Oquendo, Joseph Osafo, Vikram Patel, Soumitra Pathare, Shanna Peltier, Tessa Roberts, Jo Robinson, Fiona Shand, Fiona Stirling, Jon P A Stoor, Natasha Swingler, Gustavo Turecki, Svetha Venkatesh, Waikaremoana Waitoki, Michael Wright, Paul S F Yip, Michael J Spoelma, Navneet Kapur*, Rory C O'Connor*, Helen Christensen**

Executive summary

By delivering transformative shifts in societal attitudes and initiating a radical redesign of mental health care, we can fundamentally improve the lives of people who self-harm.

This *Lancet* Commission is the product of a substantial team effort that has taken place over the last five years. It consolidates evidence and knowledge derived from empirical research and the lived experience of self-harm. Self-harm refers to intentional self-poisoning or injury, irrespective of apparent purpose, and can take many forms, including overdoses of medication, ingestion of harmful substances, cutting, burning, or punching. The focus of this Commission is on non-fatal self-harm—however, in some settings, distinctions are not this clear cut. Self-harm is a behaviour, not a psychiatric diagnosis, with a wide variety of underlying causes and contributing factors. It is shaped by culture and society, yet its definitions have arisen from research conducted mainly in high-income countries. The field has often overlooked the perspectives of people living in low-

For people who self-harm, the behaviour serves a variety of functions, including self-soothing, emotional management, communication, validation of identity, and self-expression. Self-harm practices are also shaped by social relationships and class dynamics. Indigenous peoples across the world, especially Indigenous youth, have high rates of self-harm, with colonisation and racism playing potentially important roles in driving the behaviour. Numerous psychological and social factors are associated with self-harm and the social determinants of health—poverty, in particular, heavily influences the distribution of self-harm within all communities. Yet we know little about how individual-level factors interact with social context to drive self-harm, or whether an individual might be more likely to engage in self-harm at a particular point in time. Furthermore, many of the biopsychosocial mechanisms underlying self-harm remain elusive. Granular data capture through Ecological Momentary Assessment, together with machine learning and triangulation of data sources, including qualitative data, could help to shed light on the nature and timing of self-harm.

Published Online October 9, 2024 https://doi.org/10.1016/S0140-6736(24)01121-8

See Online/Comment https://doi.org/10.1016/S0140-6736(24)01941-X

See Online/Perspectives https://doi.org/10.1016/S0140-6736(24)02125-1, https://doi.org/10.1016/S0140-6736(24)02127-5, and https://doi.org/10.1016/S0140-6736(24)02126-3

*Executive Group

†Lead commissioner for lived experience

‡Lead commissioner for Indigenous perspectives

§Lead commissioner for individual perspectives

¶Lead commissioner for LMICs

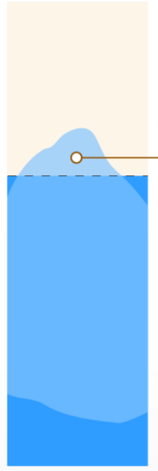
||Joint lead commissioners for societal perspectives

Centre for Academic Mental

The *Lancet* commission on self-harm

Self-harm refers to intentional self-poisoning or injury, irrespective of apparent purpose, and can take many forms including overdoses of medication, ingestion of harmful substances, cutting, burning, or punching. Self-harm is shaped by culture and society, and has been neglected by governments internationally.

There are lots of reasons why people self-harm. For some it's a way of managing unbearable pain. For others though, self-harm is a precursor to suicide.



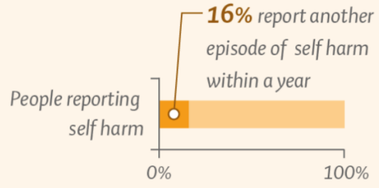
At least **14 million** self-harm events are recorded worldwide each year

This figure is likely to be an underestimate due to under-reporting and lack of routine surveillance systems, **especially in Low-middle income countries (LMICs).**

International community and school-based surveys suggest a higher lifetime prevalence in adolescents than adults.

1-in-6 *adolescents*

Repetition of self-harm is common



Approximately 50% *of people who die by suicide in the UK have a history of self-harm.*

Read the full *Lancet* Commision report for more details

The *Lancet* Commission on self-harm *The Lancet* 2024. Published online October 9. https://www.thelancet.com/commissions/self-harm

University of Glasgow

From Thinking To Doing

Interventions to Interrupt the Transition from Suicidal Thoughts to Suicide Attempts

University of Glasgow

2019

nature reviews disease primers

Box 2 | Interventions for suicidal ideation and suicidal behaviour

Psychosocial

Longer-term psychosocial interventions

- Cognitive behavioural therapy
- Dialectic behavioural therapy
- Collaborative assessment and management of suicidality
- Acceptance and commitment therapy
- Mentalization
- Interpersonal psychotherapy

Brief interventions

- Caring contacts
- No suicide contacts
- Safety planning intervention
- Crisis response planning
- Attempted suicide short intervention programme
- Volitional help sheet

Pharmacological

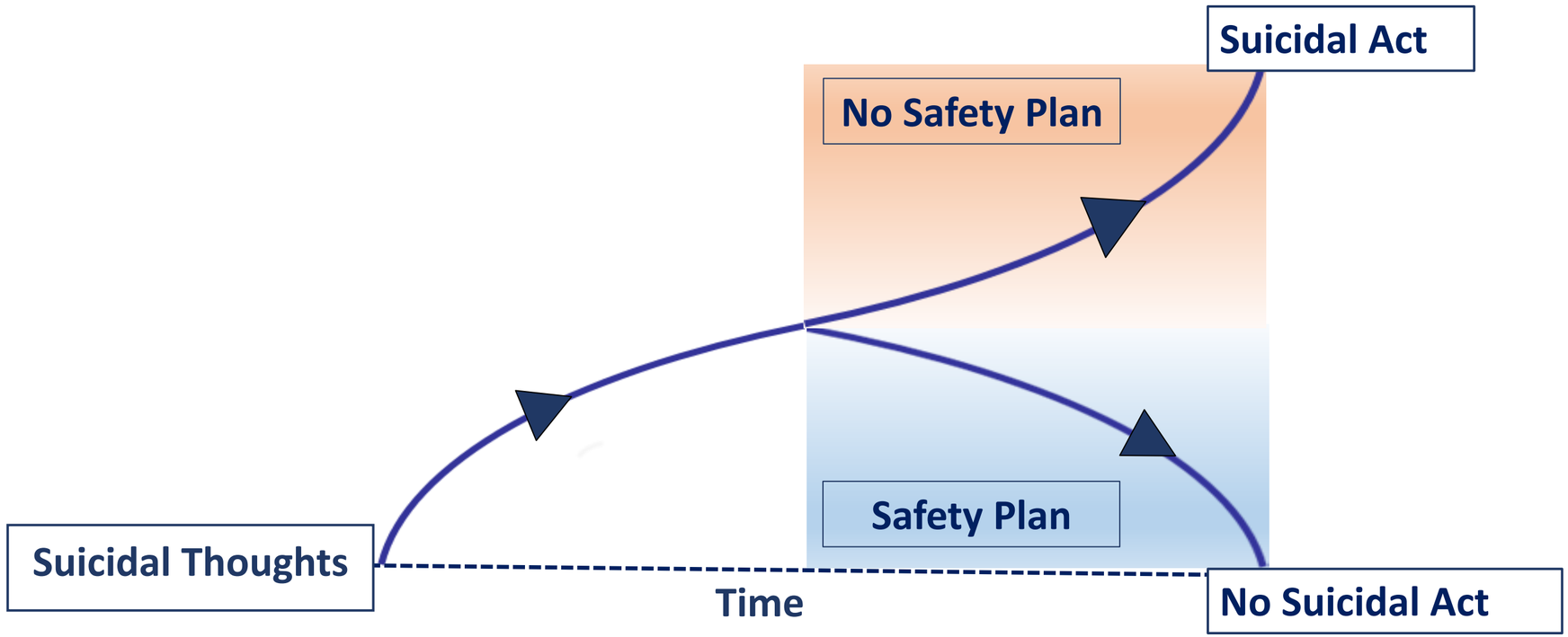
Pharmacological agents with potential effect on suicidal behaviour

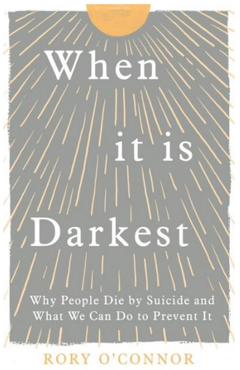
- Lithium
- Clozapine[a]
- Ketamine
- Selective serotonin reuptake inhibitors
- Buprenorphine

[a]Clozapine is indicated in treatment of patients with schizophrenia who present with suicidal ideation.

Gustavo Turecki[1], David A. Brent[2], David Gunnell[3,4], Rory C. O'Connor[5], Maria A. Oquendo[6], Jane Pirkis[7] and Barbara H. Stanley[8]*

Utility of a Safety Plan to interrupt the transition from suicidal thoughts to suicidal acts





@suicideresearch

Safety Planning

It has six components:

i) identifying warning signs of an impending suicidal crisis
ii) utilising internal coping strategies
iii) engaging social contacts & social settings to distract from suicidal thoughts
iv) contacting social supports for assistance in resolving the suicidal crisis
v) contacting mental health professionals
vi) minimising access to lethal means.

SAFETY PLAN

Step 1: Warning signs (thoughts, mood, situation, behaviour) that a crisis may be developing

1._____
2._____
3._____

Step 2: Internal coping strategies - things I can do to take my mind off my problems (relaxation, activity)

1._____
2._____
3._____

Step 3: People and social settings that provide a distraction

1. Name _____ Phone_____
2. Name _____ Phone_____
3. Place _____ 4. Place_____

Step 4: People who I can ask for help

1. Name _____ Phone_____
2. Name _____ Phone_____
3. Name _____ Phone_____

Step 5: Professionals or services I can contact during a crisis

1. Contact Name _____ Phone_____
   Emergency contact number _____
2. Contact Name _____ Phone_____
   Emergency contact number _____
3. Crisis services phone _____
   Crisis services address _____
4. Helpline support (freephone): Samaritans 116 123 Breathing Space 0800 83 85 87

Step 6: Making the environment safe

1._____
2._____

University of Glasgow

Safety planning-type interventions for suicide prevention: meta-analysis

BJPsych The British Journal of Psychiatry (2021) 219, 419–426. doi: 10.1192/bjp.2021.50

Chani Nuij, Wouter van Ballegooijen, Derek de Beurs, Dilfa Juniar, Annette Erlangsen, Gwendolyn Portzky, Rory C. O'Connor, Johannes H. Smit, Ad Kerkhof and Heleen Riper

The relative risk of suicidal behaviour among patients who received an SPTI compared with control was 0.570 (95% CI 0.408–0.795, P = 0.001)

Results support the use of SPTIs to help preventing suicidal behaviour and the inclusion of SPTIs in clinical guidelines for suicide prevention.

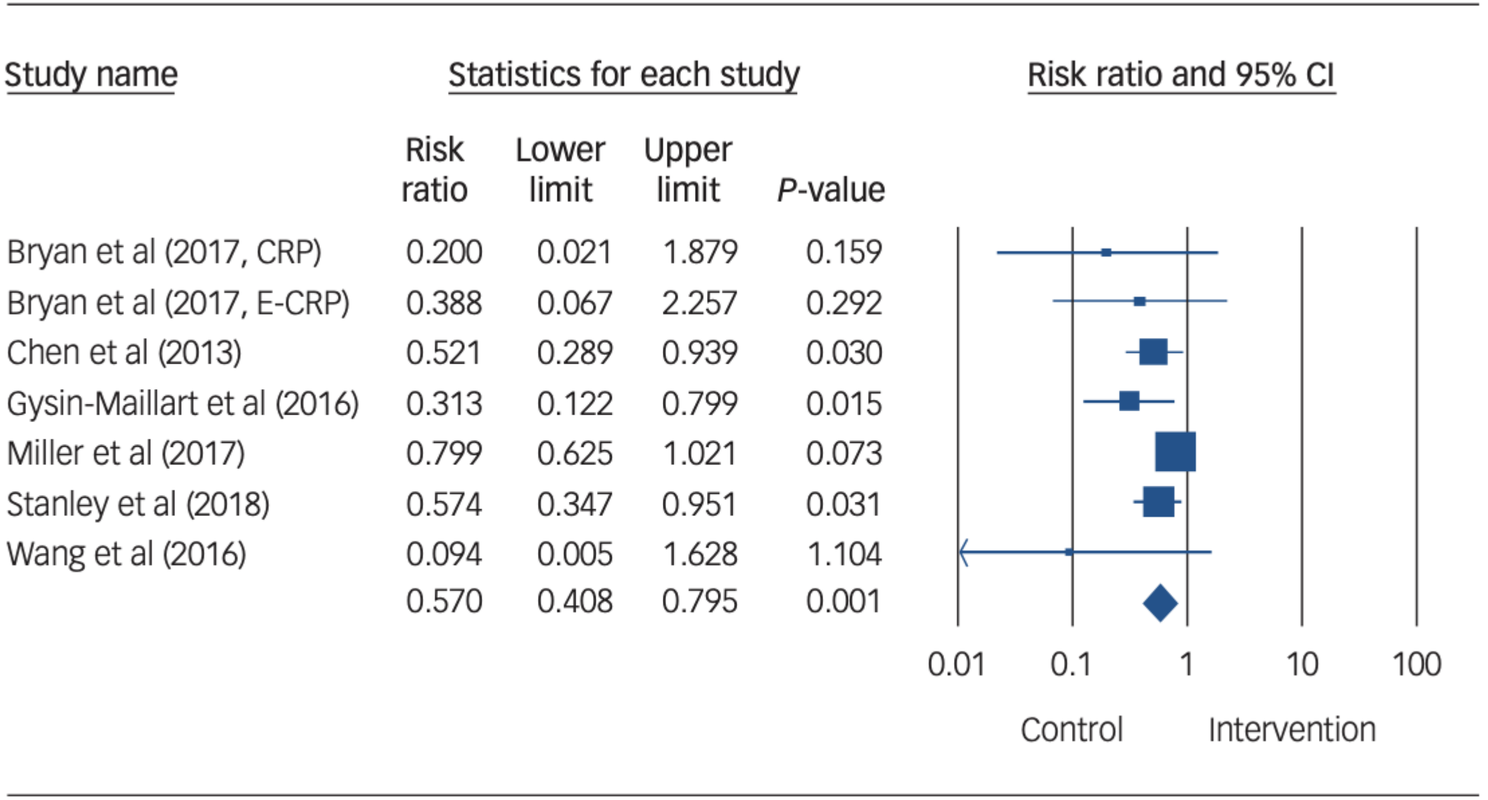


Fig. 2 Forest plot for suicidal behaviour. CRP, standard crisis response plan; E-CRP, enhanced crisis response plan.

SPTI: Safety Planning-type interventions

O'Connor *et al. Pilot and Feasibility Studies* (2022) 8:156
https://doi.org/10.1186/s40814-022-01081-5

Pilot and Feasibility Studies

RESEARCH Open Access

SAFETEL: a pilot randomised controlled trial to assess the feasibility and acceptability of a safety planning and telephone follow-up intervention to reduce suicidal behaviour

Rory C. O'Connor[1*], Susie Smillie[2], Heather McClelland[1], Jenna-Marie Lundy[1], Corinna Stewart[1], Suzy Syrett[2], Marcela Gavigan[3], Alex McConnachie[4], Bethany Stanley[4], Michael Smith[5], Gregory K. Brown[6], Barbara Stanley[7] and Sharon A. Simpson[2]

Abstract

Background: A previous suicide attempt is an important predictor of future suicide. However, there are no evidence-based interventions administered in UK general hospital contexts to reduce suicidal behaviour in patients admitted following a suicide attempt. Consequently, the objective of this pilot randomised controlled trial was to explore whether a safety planning and telephone follow-up intervention (SAFETEL) was feasible and acceptable for individuals treated in hospital following a suicide attempt.

Methods: In this three-phase study with an embedded process evaluation, a safety planning intervention was tailored to the UK context (Phase I), piloted (Phase II, $n = 32$), and tested in a feasibility randomised controlled trial (Phase III). In Phase III, participants were allocated to either the intervention ($n = 80$) or control group ($n = 40$) using telephone randomisation with a 2:1 ratio. The acceptability and feasibility of the trial and intervention procedures were evaluated using both qualitative (interviews and focus groups) and quantitative data. The number of hospital representations of suicidal behaviour was also collected 6 months after study recruitment based on electronic patient records.

Results: Findings indicated that SAFETEL was both acceptable and feasible. Hospital staff reported the intervention fitted and complemented existing services, and patients reported that they favoured the simplicity and person-centred approach of the safety planning intervention.

Conclusions: All progression criteria were met supporting further evaluation of the intervention in a full-scale clinical effectiveness trial.

Trial registration: ISRCT,ISRCTN62181241, 5/5/2017

Keywords: Suicide, Self-harm, Feasibility study, Safety planning, Randomised controlled trial (RCT), Telephone support, Process evaluation

- 6 in 10 of the intervention group participants who completed a Safety Plan said they had used it at least once since baseline

- All progression criteria were met

Remote psychosocial interventions to prevent avoidable psychiatric hospital admissions in people with serious mental health problems: a multi-arm multi-stage trial - RAPID TRIAL

SAFETEL + TAU *v* PREVAIL + TAU *v* LwST + TAU *v* TAU

4-arm, 2 stage RCT comparing 3 brief, remote interventions to TAU.
Primary Outcome: a reduction in psychiatric hospital admissions over 6 months
& reductions in suicidal ideation & be cost-effective over 6 months.

Principal Investigator & Co-Investigators

Tony Morrison (PI), Pyle, Longden, Peel, Bucci, Shields (Manchester)
Gumley, O'Connor, Simpson, Allan (Glasgow)
Wood, Gillard, Emsley (London)
Christensen (Sydney)
Freeman (Oxford), Pfeiffer (Michigan)

NIHR | National Institute for Health and Care Research

2022-2025

SAFETEL: Safety planning + telephone support
PREVAIL: Peers for Valued Living
LwST: Living with Suicidal Thoughts

University of Glasgow

Lancet Psychiatry 2023

Gone Too Soon: priorities for action to prevent premature mortality associated with mental illness and mental distress

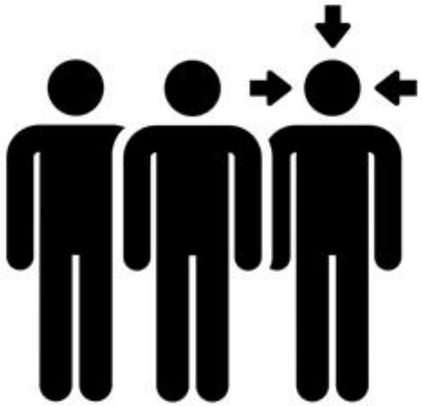
Rory C O'Connor, Carol M Worthman*, Marie Abanga, Nikoletta Athanassopoulou, Niall Boyce, Lai Fong Chan, Helen Christensen, Jayati Das-Munshi, James Downs, Karestan C Koenen, Christine Yu Moutier, Peter Templeton, Philip Batterham, Karen Brakspear, Richard G Frank, Simon Gilbody, Oye Gureje, David Henderson, Ann John, Wilbroad Kabagambe, Murad Khan, David Kessler, Olivia J Kirtley, Sarah Kline, Brandon Kohrt, Alisa K Lincoln, Crick Lund, Emily Mendenhall, Regina Miranda, Valeria Mondelli, Thomas Niederkrotenthaler, David Osborn, Jane Pirkis, Anthony R Pisani, Benny Prawira, Hala Rachidi, Soraya Seedat, Dan Siskind, Lakshmi Vijayakumar, Paul S F Yip*

MQ Mental health research

Strategies to reduce stigma, discrimination, marginalization, gender violence & victimisation

Lancet Psychiatry 2023

O'Connor et al. (2023)



#GoneTooSoon

The effect of interventions directed at reducing stigma, discrimination, marginalisation, and gender violence at any level reverberates across the social ecosystem.

MQ Mental health research

University of Glasgow

Lancet Psychiatry 2023

Published Online
May 11, 2023

O'Connor et al. (2023)

Improve access to effective treatments and personalised medicine

#GoneTooSoon

Personalised care with targeted mechanisms of action and fewer side-effects is crucial.
Compassion must be embedded in all aspects of service provision, and continuity of care for those in suicidal crisis is vital.

MQ Mental health research

University of Glasgow

Lancet Psychiatry 2023

Published Online
May 11, 2023

O'Connor et al. (2023)

Better understanding of interplay between biomarkers & psychosocial risk factors

#GoneTooSoon

Analyses of big data incorporating genetic, epigenetic, biochemical, neuroimaging, and psychological factors; real-time digital phenotyping; and electronic clinical records hold promise as the next frontier in personalised medicine.

MQ Mental health research

My 4 Cs
of
Suicide Prevention

Compassion

Complexity

Care

Connection

@suicideresearch

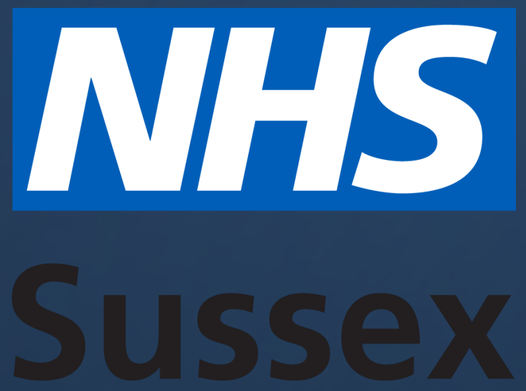
“I am terribly sorry for having chosen to take my own life, but I have just reached the point where I feel that I have no alternative…The feeling of being helpless and incapable is something that I am unable to cope with. I can’t see any future other than a continual decline into a situation of helplessness and even worse unhappiness which is not something that I think I can bear…It is the unrelenting nature of the depression and the way that it robs me of everything…, and which despite my best efforts seems to be impossible for me to overcome that gives me no hope for the future…”

Stories of hope and collaboration

- Wendy Robinson, Service Manager, Rethink Mental Illness
- Robert Koch, Suicide Prevention Lived Experience Advisory Group

GRASSROOTS
SUICIDE PREVENTION

SOS & MENDOS Service
&
NHS
Bereavement By Suicide Support



Introducing Our Services & Background Information

The SOS & MENDOS Rethink (Subcontracted) service is one of 18 organizations part of the South down UOK Psychosocial network in Brighton and Hove areas.

Suicide Bereavement Contract: In 2020, we were awarded a contract by NHS Sussex to support those who have been affected by bereavement of suicide as part of a across Sussex early intervention initiative. We work in partnership with 3 other bereavement providers with West Sussex and East Sussex areas and are funded by Public Health.

- Person was working
- Studying
- Had leisure interests
- Married
- Pets
- Family
- Friends

Identified Blocks preventing Support

- They had not dared tell others how they really were, in case they walked away

Most identified Pre trigger points

Long Term Illness physical or mental health ie; interrupted sustained wellness quality of life

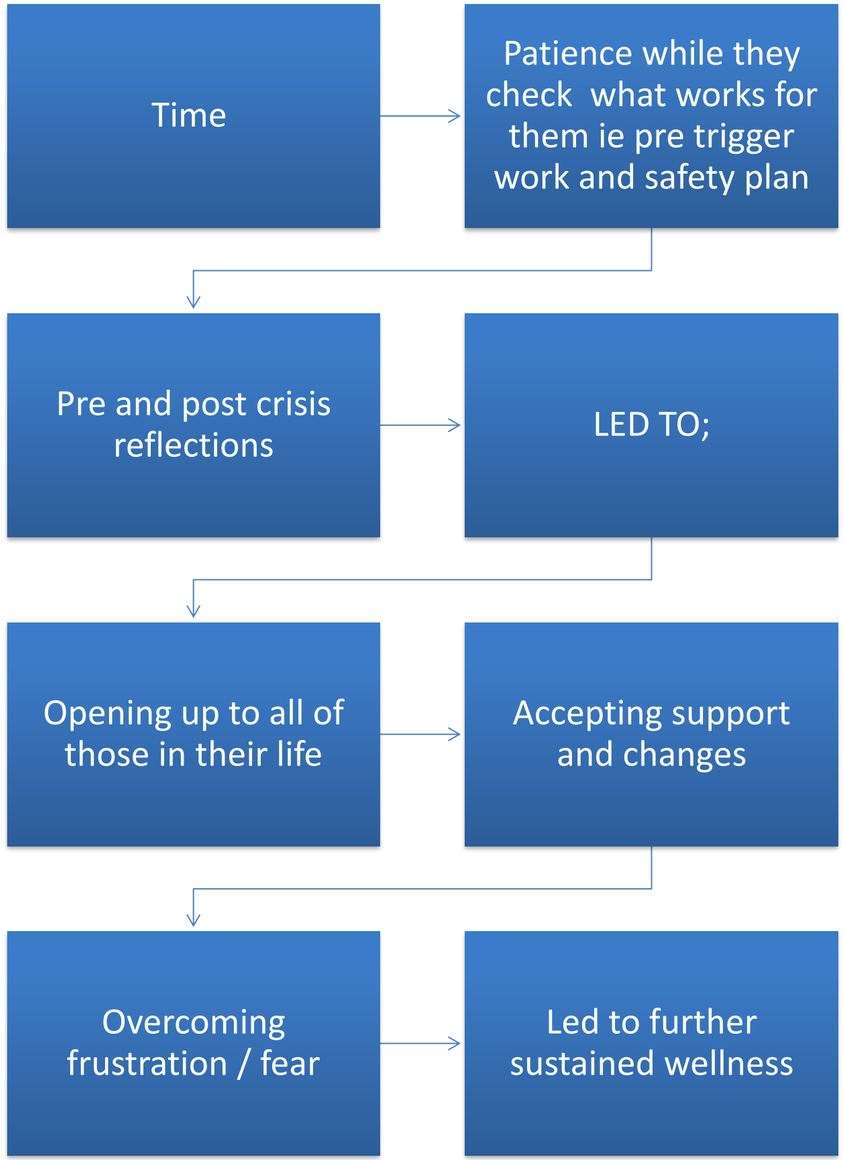
Coping with diagnosis and / or not comfortable with diagnosis; Stigma

Relationship breakdown or loss of job or fear of loss of either – can't tell anyone, Isolation

Self worth – ie Types of Historic or current Abuse. Other factors; Bullying can change peoples pathway from youth to adult

Substance misuse history or Criminal justice

Space to Understand



A Final Thought

We never work in isolation;

All the support;

Murrs, Crisis Team, ATS, GP's, Millview Staff, Police, ambulance crews and many other voluntary support, Signposting to websites and organisations across the city

Their family and friends

Importantly themselves - trying to see what can give most relief.

People need Time

It takes a Community to support a community

Keep people central to their care and treatment – Learn from their experience E

Expert By Experience

Thank you to SOS service

'I was supported by the survivor of Suicide service in Brighton when was severely mentally unwell.

I have struggled with my mental health throughout my life.

The support I received was life saving. I don't think I would be here without this support

Round-up of the day

- Emma Mills-Sheffield, Chair of Trustees for Grassroots Suicide Prevention – questions about your day on Menti
- Rachael Swann, CEO of Grassroots Suicide Prevention

GRASSROOTS
SUICIDE PREVENTION

Rachael Swann,
CEO
October 2024

GRASSROOTS
SUICIDE PREVENTION

What next…

- Feedback survey
- Follow up meeting with our working group with Public Health, SPFT, VCSE and lived experience to review the outcomes of the conference; thoughts, reflections and insights and then we will feedback to everyone who attended

GRASSROOTS
SUICIDE PREVENTION

Suicide Prevention Network

- Regular updates on suicide prevention
- Quarterly online learning events
- Collaboration with the online suicide prevention hubs www.prevent-suicide.org.uk
  - Children and young people and suicide prevention
  - Older adults and suicide prevention (in partnership with SPFT)
  - Women and suicide prevention (in partnership with 10 specialist charities)
  - Currently working on neurodivergence (in partnership with SPFT and other specialist charities)
- Sign up spnetwork@prevent-suicide.org.uk

GRASSROOTS
SUICIDE PREVENTION

Funded training in Sussex

- Brighton & Hove
  - Prevention and intervention-based training SP, MH and self-harm
  - Training for GPs coming soon
- West Sussex County Council
  - DVA and SP
- East Sussex County Council
  - Prevention and intervention-based training SP, MH and self-harm

  (other training; youth workers, bereavement tool kit, SME's)

  Contact: training@prevent-suicide.org.uk

GRASSROOTS
SUICIDE PREVENTION

Thank you

GRASSROOTS
SUICIDE PREVENTION

Sussex Suicide Prevention Conference

Working together to prevent suicide.

in partnership with

GRASSROOTS SUICIDE PREVENTION

Thank you!

Contact details
Open Sans size 44
Email address etc.

www.prevent-suicide.org.uk

GRASSROOTS
SUICIDE PREVENTION

People often worry about asking if someone is having suicidal thoughts. But talking about suicide does not give people the idea to try it. In fact, it means they are more likely to explore other options or ask for help.

Bryony Gordon

Children and young people and suicide prevention

- Nicola Rosenberg, Public Health Consultant West Sussex County Council
- Laura Bryan, YMCA DownsLink Group
- Joanna Johnson, Training Manager, Grassroots Suicide Prevention

GRASSROOTS
SUICIDE PREVENTION

Children and Young People
and
Suicide Prevention

Session outline

- Public Health data, strategies, policies and service developments

- YMCA support, young people’s brains and safety planning

- Breaking the Silence: research on developing lessons on suicide prevention for young people aged 14+

Discussion

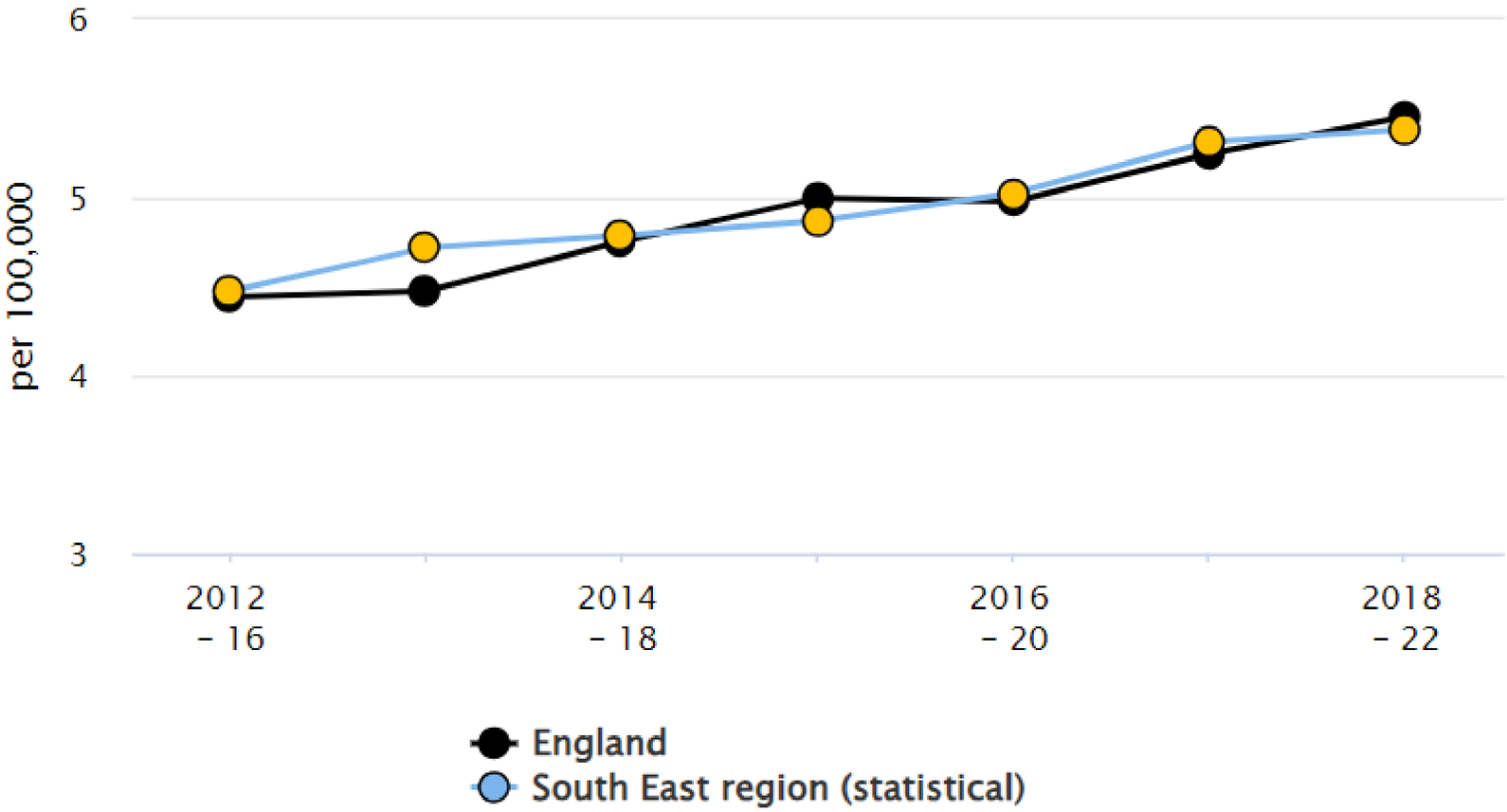
Responsibility and looking after ourselves

- *Inaccurate and misleading information about suicide and self-harm clusters can cause real-world harm to children and young people, it can modify the risk of contagion and cause adverse negative reactions to people who receive it.*

- *Holding everyone in mind*

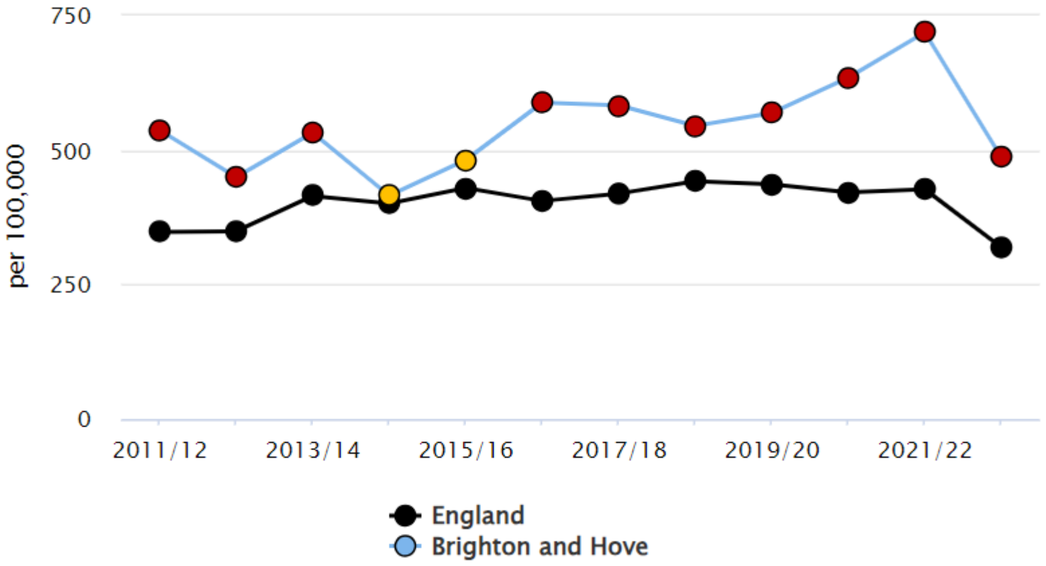
- *The death or serious harm of a child is a distressing event for everyone. Staff attending today are encouraged to access support that is available here at the conference, discuss issues of support within their usual line management arrangements and make use of any additional support offers in place within their agency. It is expected that offers of support should be ongoing and able to be accessed at any time.*

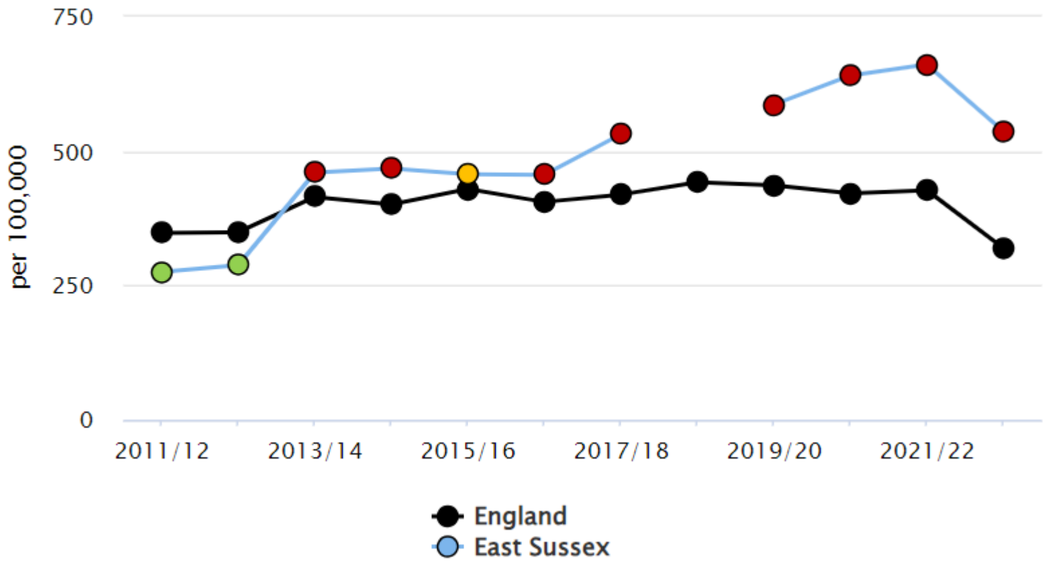
South-East and England suicide rate for persons aged 10- 24 years (5.4 per 100,000 2018 – 2022)

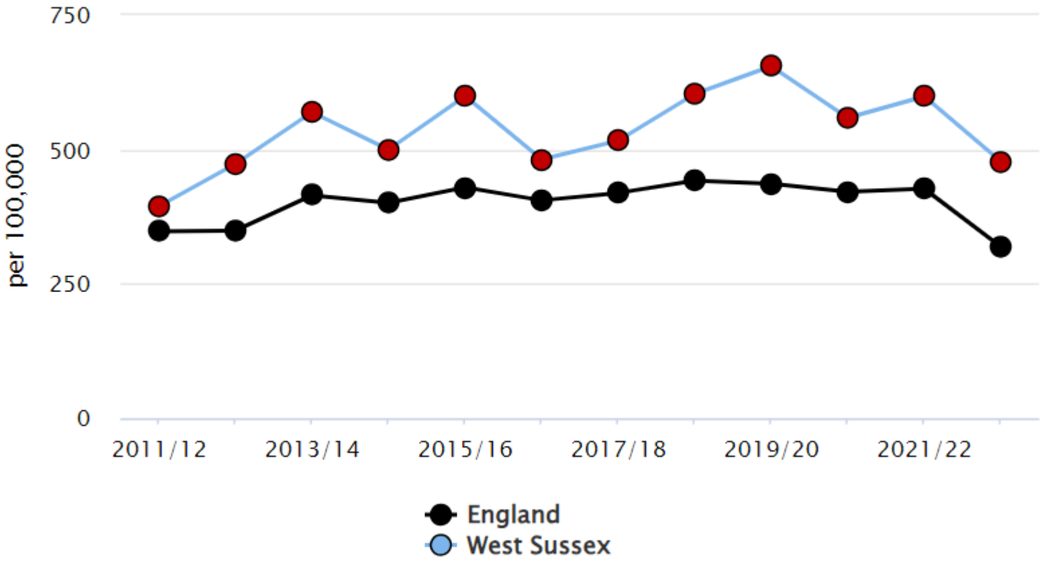


Suicide Prevention | Fingertips | Department of Health and Social Care (phe.org.uk)

Hospital admissions as a result of self-harm 10 – 24 years







[Children and Young People's Mental Health and Wellbeing | Fingertips | Department of Health and Social Care (phe.org.uk)]

Suicide Prevention – new national strategy

New national strategy published 11th September 2023 Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)

Priority groups

- children and young people
- middle-aged men
- people who have self-harmed
- people in contact with mental health services
- people in contact with the justice system
- autistic people
- pregnant women and new mothers

Risk factors at a population level

- Physical illness
- Financial difficulty and economic adversity
- Gambling
- Alcohol and drug misuse
- Social isolation and loneliness
- Domestic abuse

Sussex Suicide prevention strategy 2024-2027
Vision and Aims

Sussex Health&Care

In line with the national strategy, the aims of the Sussex Suicide prevention Strategy and Action Plan are to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- improve support for people who have self-harmed.
- improve support for people bereaved by suicide.

It is our vision that Sussex is a place where:

- we are committed to reducing the risk factors and increasing the protective factors for suicide across the life course.
- we build individual and community resilience to improve lives and prevent people falling into crisis by tackling the risk factors for suicide.
- we recognise that suicides can be prevented, and that people do not inevitably end up considering suicide as a solution to the difficulties they face.

National Strategy - Priority areas for action

1. **Improving data and evidence** to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. **Tailored, targeted support to priority groups**, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
3. **Addressing common risk factors** linked to suicide at a population level to provide early intervention and tailored support.
4. **Promoting online safety and responsible media** content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. **Providing effective crisis support** across sectors for those who reach crisis point.
6. **Reducing access to means and methods** of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. **Providing effective bereavement support** to those affected by suicide.
8. **Making suicide everybody's business** so that we can maximise our collective impact and support to prevent suicides.

Local Suicide Prevention Frameworks and action plans 2023 - 2027

East Sussex

- Accessible template for reports and policies in Word (green branding) (eastsussex.gov.uk)

Brighton and Hove

- BH suicide prevention Action Plan 2024-2027 - final.pdf (brighton-hove.gov.uk)

West Sussex

- Self-Harm and Suicide Prevention - West Sussex JSNA Website

CYP suicide prevention policies

Being updated via the Sussex safeguarding partnership

- 14.2 Response to a suspected suicide | Sussex Child Protection and Safeguarding Procedures Manual
- 8.3 Responding to a potential cluster of suicides for children and young people aged under 18 | Sussex Child Protection and Safeguarding Procedures Manual
- 14.1 Self-harm, suicidal behaviour & suicide | Sussex Child Protection and Safeguarding Procedures Manual

In development

- Response to the unexpected death of a care leaver up to age 24 years

- Unexpected deaths in schools toolkit – each place has one

Snapshot of service developments in West Sussex

- Multi-agency Mental Health in Education Triage (MAMHET)
  - brings together professionals to identify and respond to presentations of children in school which might progress to the point of a mental health crisis, self-harm, or potential risk of suicide,
  - triage service identifies individuals or groups of young people who might be at risk, offers a person-centred approach to supporting them.
  - countywide service, it works with schools, colleges, the council, Sussex Police, and the NHS.
- Single Point of Access for CYP mental health support (SPOA)
- Sussex Police – Real Time Surveillance notification system of suspected suicide
- Public mental health needs assessment including children and young people's LGBTQ+ mental health
- Suicide prevention and trauma informed practice training
- West Sussex Suicide Prevention and Mental Health Communications Strategy
- Self-Harm Learning Network – for CYP, parents and carers and professionals (Conference 12th Nov 24)
- Mental Health in Schools team (Thought-full) and LGBTQ+ training for schools
- Sussex CAMHS paediatric liaison teams
- Bereavement support to support children and young people bereaved through suicide

Thank you

YMCA Dialogue

Suicide Prevention: children and young people

Laura Bryan - Therapy Lead for West Sussex Community Counselling

Who are we?

- Therapeutic support for children and young people in Sussex
- West Sussex community, Schools, Brighton and Hove
- Mild to moderate mental health support
- Short term interventions
- Counselling and CBT

Presentation in Young People

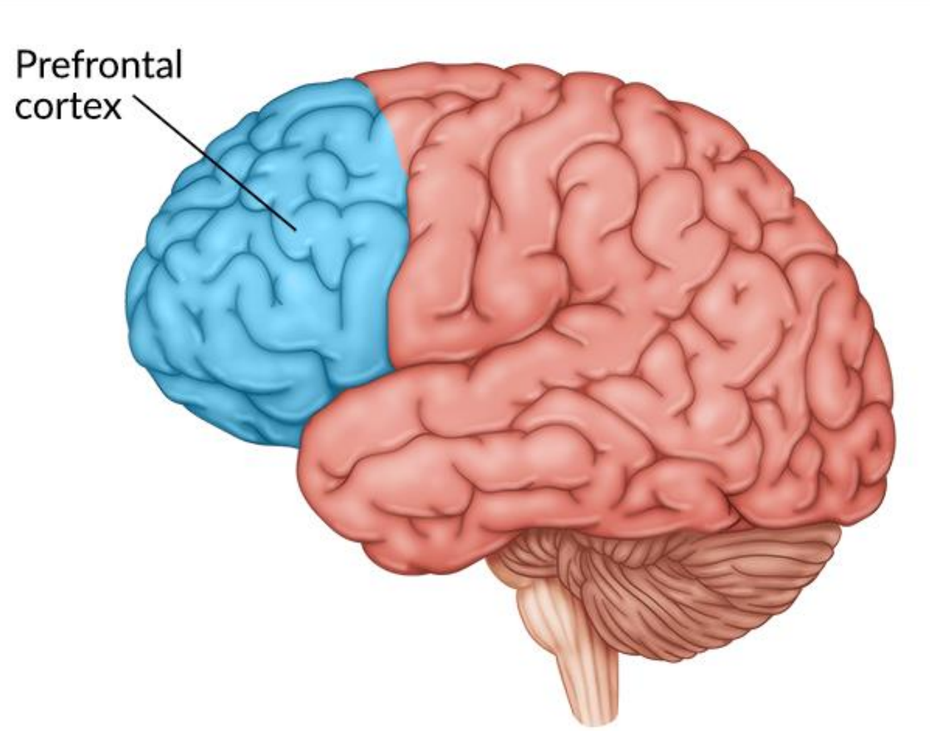
- Expressing feelings of worthlessness, guilt, or shame
- Withdrawing
- Losing interest in things they normally enjoy
- Losing interest in their appearance
- An interest in death
- Behaving ‘out of character’

The Developing Brain

Let’s take a look at the brain: Prefrontal Cortex

(Executive functioning)

- Decision making
- Logical thinking
- Planning
- Organisation
- Impulse control

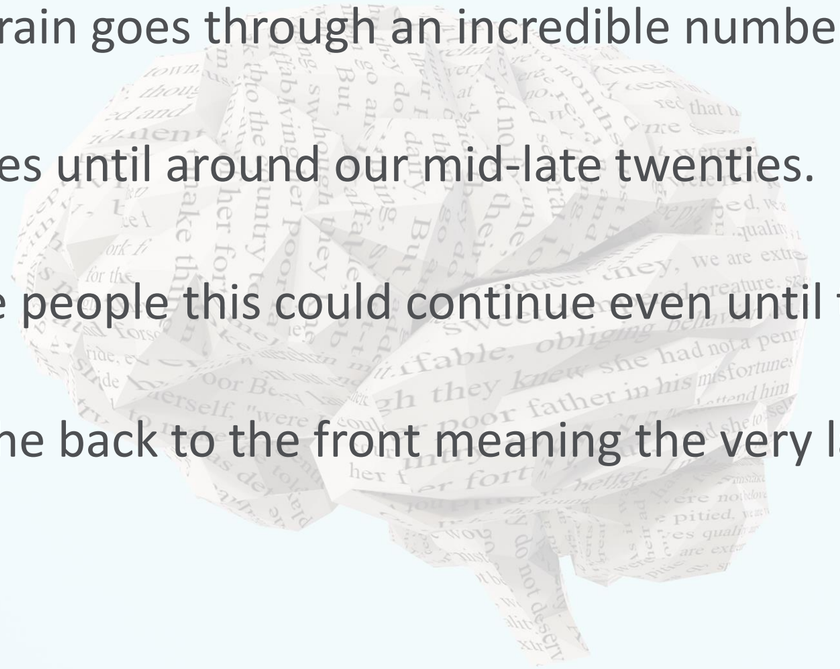


Let’s take a look at the brain: The Amygdala

(the emotional brain)

- Processing emotions
- Particularly linked to fear and anger
- ‘Fight or Flight’

Brain Development

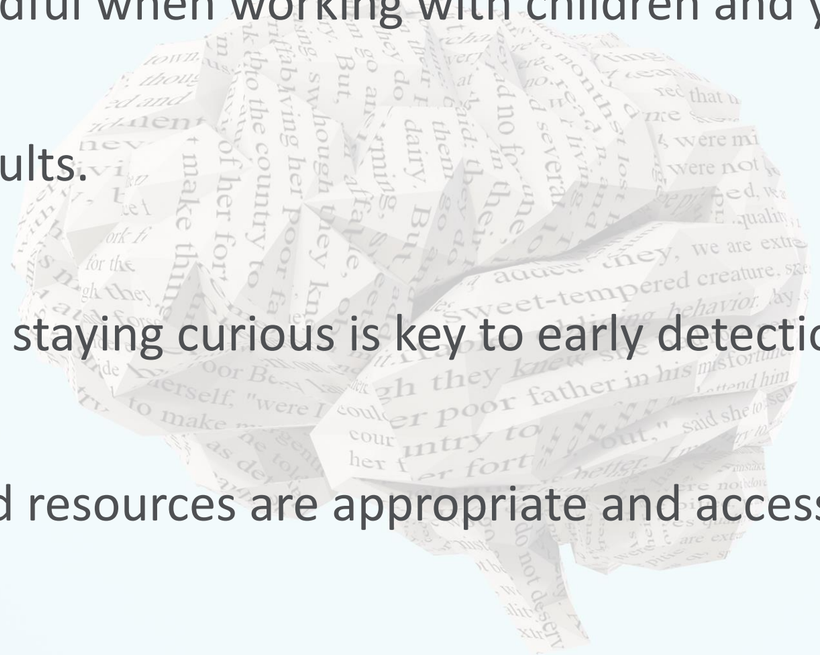


- During adolescence, the brain goes through an incredible number of changes very quickly.
- This development continues until around our mid-late twenties.
- Research suggests in some people this could continue even until their thirties!
- Our brains develop from the back to the front meaning the very last part to develop is the prefrontal cortex.

“Adults have the ability to think with the pre-frontal cortex, the brain's rational part. This is the part of the brain that responds to situations with good judgment and an awareness of long-term consequences.

Teens process information with the amygdala, the emotional part”

Why is this important?



- It is important to be mindful when working with children and young people that they may present differently to adults.
- Holding this in mind and staying curious is key to early detection and prevention.
- Making sure support and resources are appropriate and accessible for children and young people.

Safety Planning with Young People

- The importance of safety planning
- Engaging the young person- thinking about language used
- Involving key people in the safety plan (parents/school/counsellor)
- Signposting and resources

Working Together in Suicide Prevention

- YMCA and the Single Point of Access
    - Allows quick escalation and correct support
    - Working together with YES and CAMHS
- YMCA and MAHMET
    - Sharing information
    - Connecting schools and service together

Created in partnership

DAVIDRIDDELL.ORG
DESTIGMATISING MENTAL ILLNESS

Breaking the Silence: funded by the David Riddell Memorial CIO.

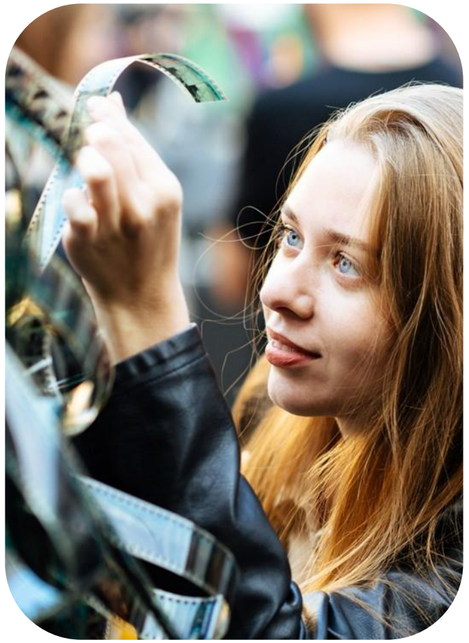
GRASSROOTS
SUICIDE PREVENTION

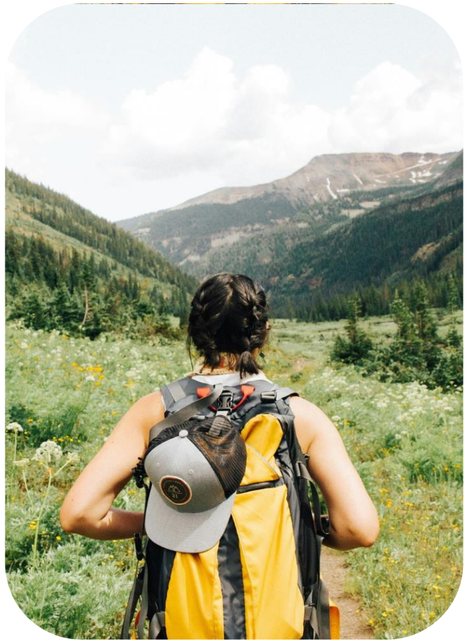
Experts in suicide prevention, training organisations and individuals for over twenty years on mental health, self-harm and suicide prevention/postvention.

Breaking the Silence

Saving young people's lives…

GRASSROOTS
SUICIDE PREVENTION





Breaking the Silence – the facts

- Suicide is the leading cause of death for people under 35 years old in the UK
- The number of suicides in people aged 15-19 in England is at its highest in 30 years
- Every year, around 200 UK schoolchildren die by suicide

Breaking the Silence – what is it?

A UK-first initiative to design specialist, high quality teaching resources, for teachers to deliver workshops in schools, colleges etc. on suicide prevention.

Designed for young people, with young people, to learn how to support each other if struggling with thoughts of suicide.

Breaking the Silence – what did we do?

Thanks to the funding from David Riddell Memorial CIO, we were able to:

- ❑ Produce a high quality, emotive training media clip with professional media company NICE Media, as the central focus of the suicide prevention workshops

- ❑ Design a comprehensive suite of accessible, specialist resources for teachers to deliver the workshops, through a detailed co-production process:
  - Young people, educators, academics, mental health professionals, and experts in the field
  - Workshop aims: spot the signs, respond, ask for help
  - The resources will be FREE for teachers to run the workshop sessions in schools/colleges etc.

- ❑ Work in partnership with Liverpool John Moores University academic team, to deliver pilot workshops as part of their UK-first research into suicide prevention in schools (ongoing)

e – impact (to date)

eople aged 14+

re planned)

w to spot signs and
kshop session

ey would be keen to

d to know to help

What they said – the teacher:

“The resources and learning techniques were engaging, enriching and allowed various opportunities for our people to be empathetic. The multi-media approach had our young people hooked from the start.
Staff in our school understand the importance of teaching this topic, and with these resources and the support from Grassroots, we would feel confident delivering this training."

Lucy Skillen, Mental Health and Wellbeing Lead, Holy Family Catholic School, Liverpool

What they said – the pupils:

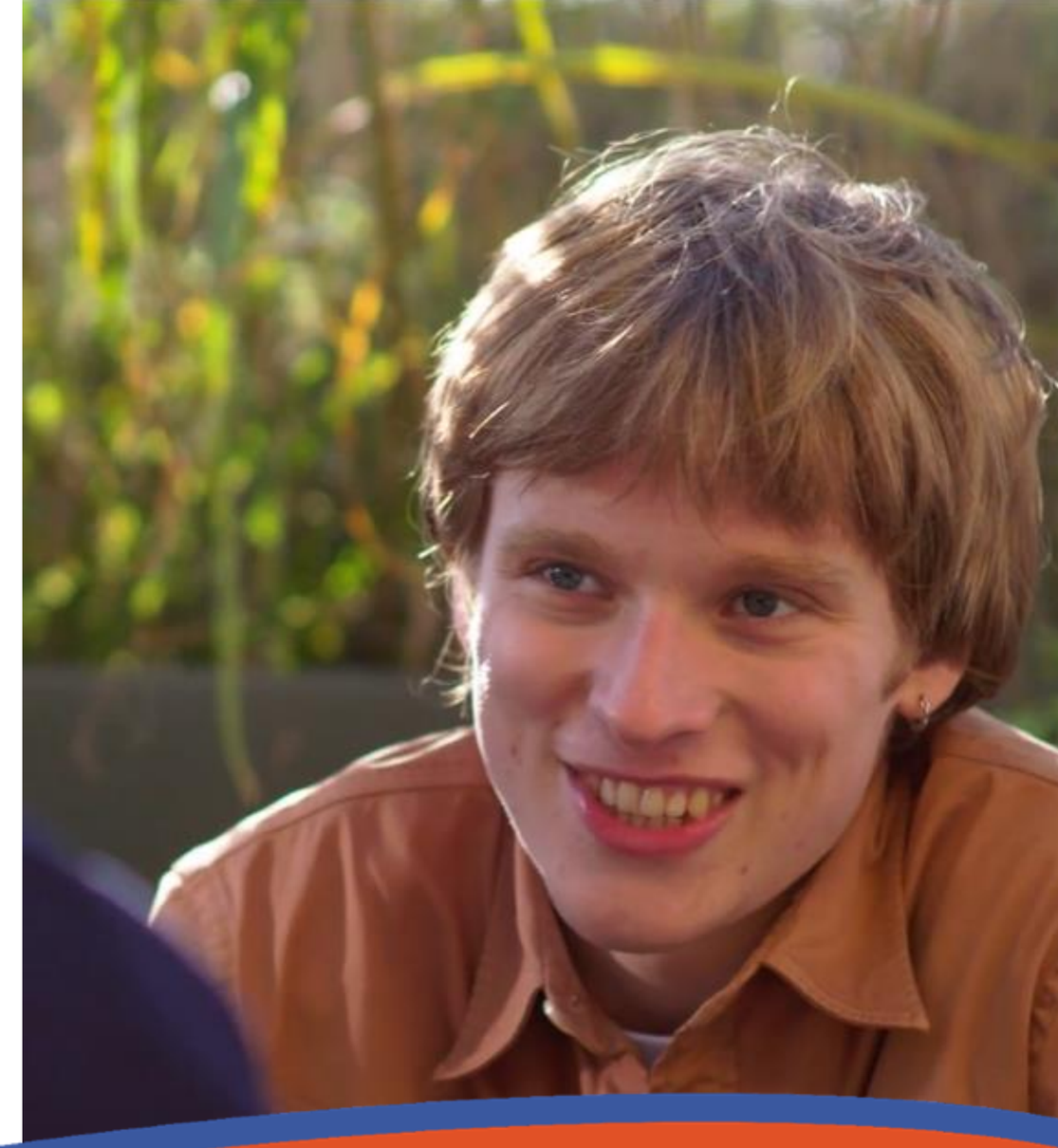
"Strong knowledge of workshops – engaged and learnt a lot (signs, importance, supporting friends, language to use)…length was perfect and enjoyed it being part of the school day…workshops were well suited for year 10s and 11s…needing skills and knowledge more in later life so keeping information stored."

Focus groups and interviews with the young people after the workshops (conducted by the academic researchers)

Thank you, for helping to save young lives

‘Breaking the Silence’, in partnership with:

David Riddell Memorial CIO



GRASSROOTS
SUICIDE PREVENTION

The Stay Alive app has helped prevent me from reaching crisis point. It helps remind me that I am loved and valuable as a human being.

Emma

Neurodivergence and suicide prevention

- Emily Nuttall, Suicide Prevention Lived Experience Advisory Group
- Dr Dawn Howard, Neurodevelopmental Services Clinical Lead at Sussex Partnership NHS Foundation Trust

GRASSROOTS
SUICIDE PREVENTION

Neurodivergence and suicide prevention

A lived experience testimony from Emily Nuttall who works for the Grassroots Suicide prevention LEAG (Lived Experience Advisory Group)

GRASSROOTS
SUICIDE PREVENTION
Educating, Connecting, Campaigning

emily@cwgsy.net

Introduction to who i am and what i do

Who am I

What are my experiences

What are my diagnoses

What do I do and where do I work

Session Plan

- ✓ What is neurodiversity.
- ✓ The experience of being neurodivergent.
- ✓ Research on increased suicide risks
- ✓ Factors contributing to increased risk
- ✓ What factors help prevent suicide longer term
- ✓ How to support in immediate crisis.
- ✓ Resources & Signposting

What is neurodiversity?

No tw

Autism

ADHD

Tics & Tourettes

Dyspraxia

Dyslexia

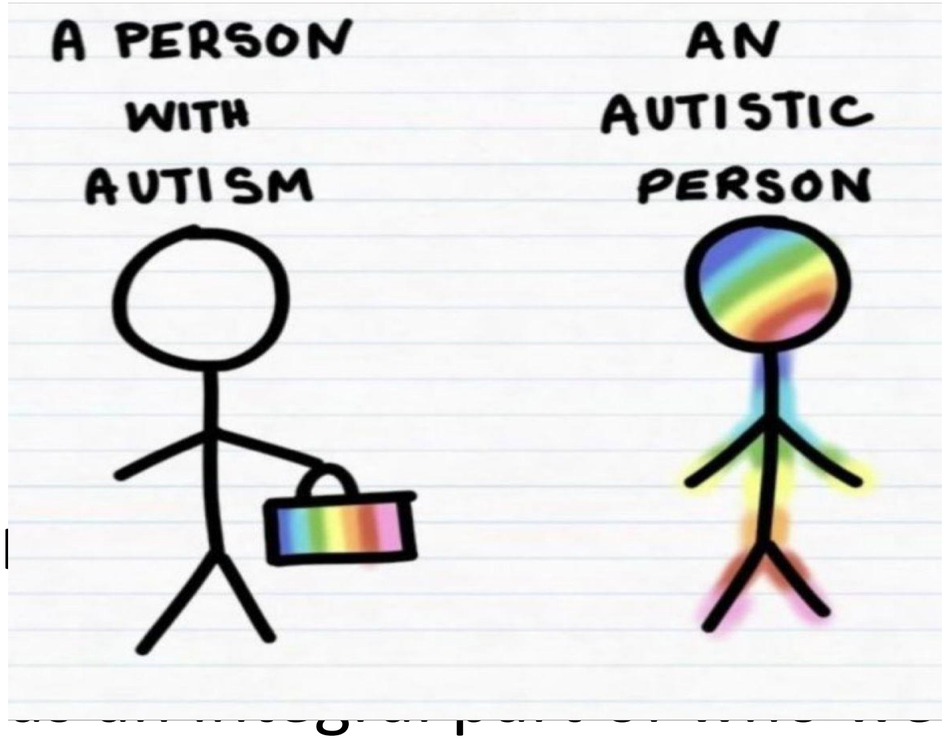
Dyscalculia

Learning Disabilities

Speech and Language Differences

Use of language

www.identityfirstautistic.org



Autistic rather than person ‘with autis

“As autistic people, we see our neurology as an integral part of who we are - not a separate or negative add-on”.

What is Autism?

Different brains process information differently and lead to differences in how the world is experienced

Social interaction & communication differences

Sensory differences

Interoception differences

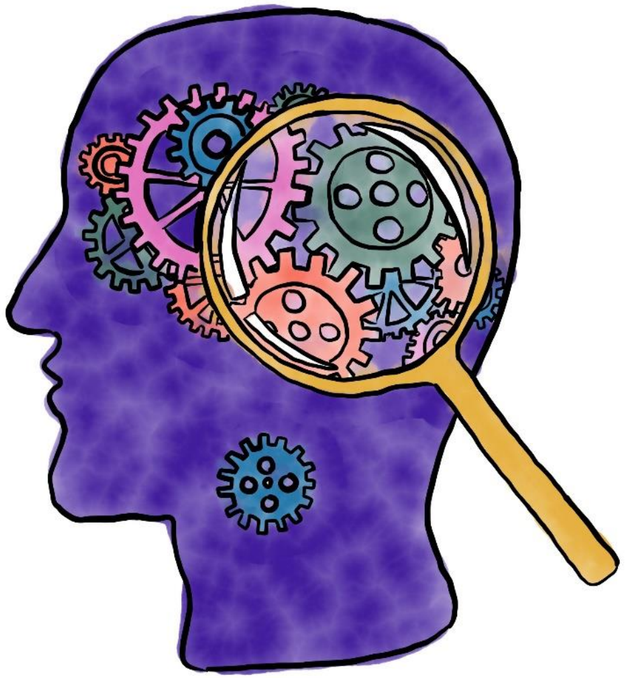
Preference for routine

Change can be distressing

Intense Passions & Interests

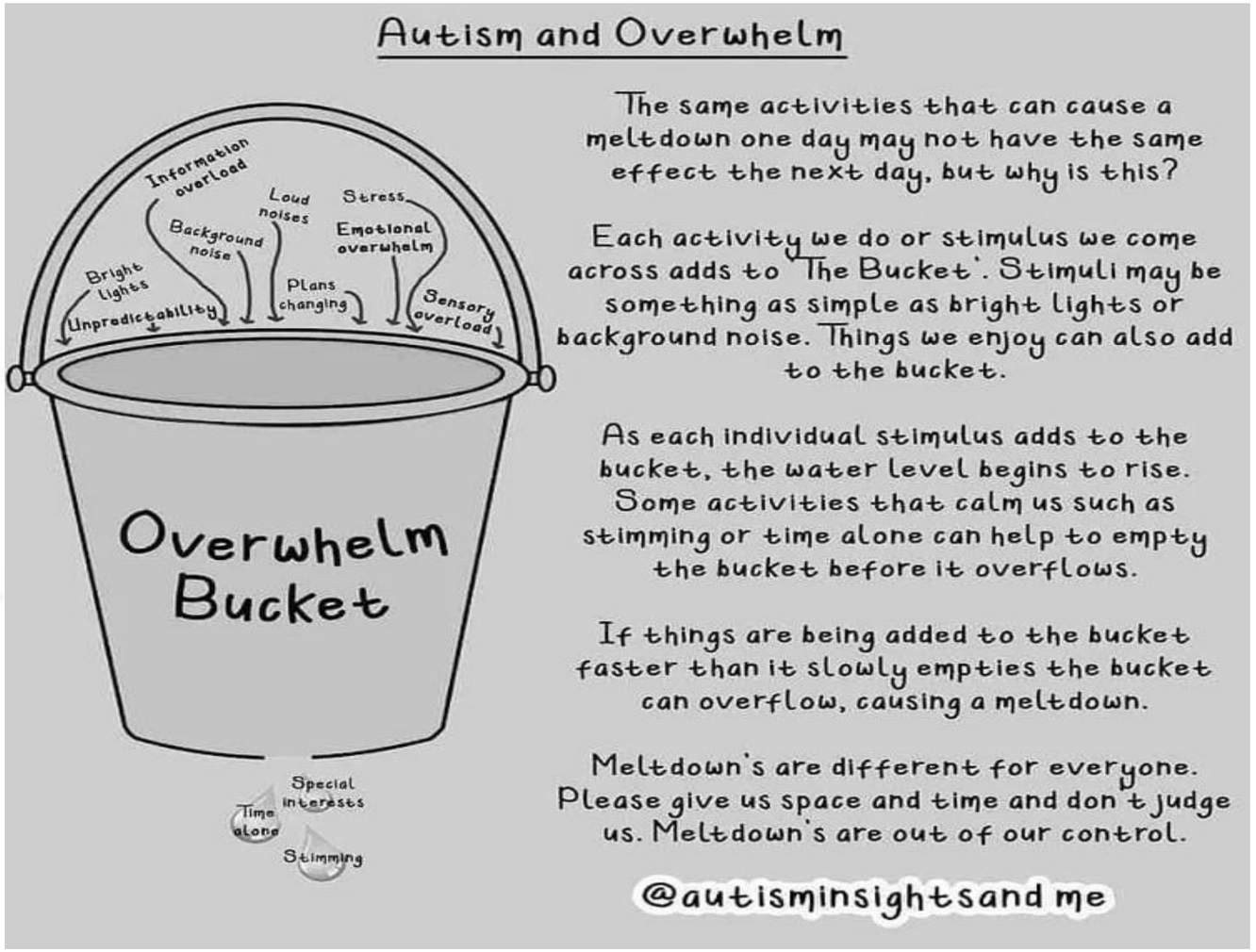
Executive functioning difficulties

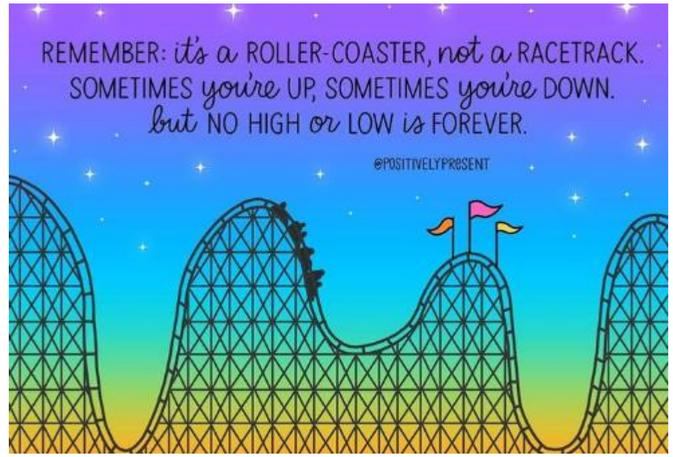
Physical health differences



@art.by.lorna

The washing machine analogy overwhelm bucket, life and recovery roller-coaster with neurodivergence and suicide



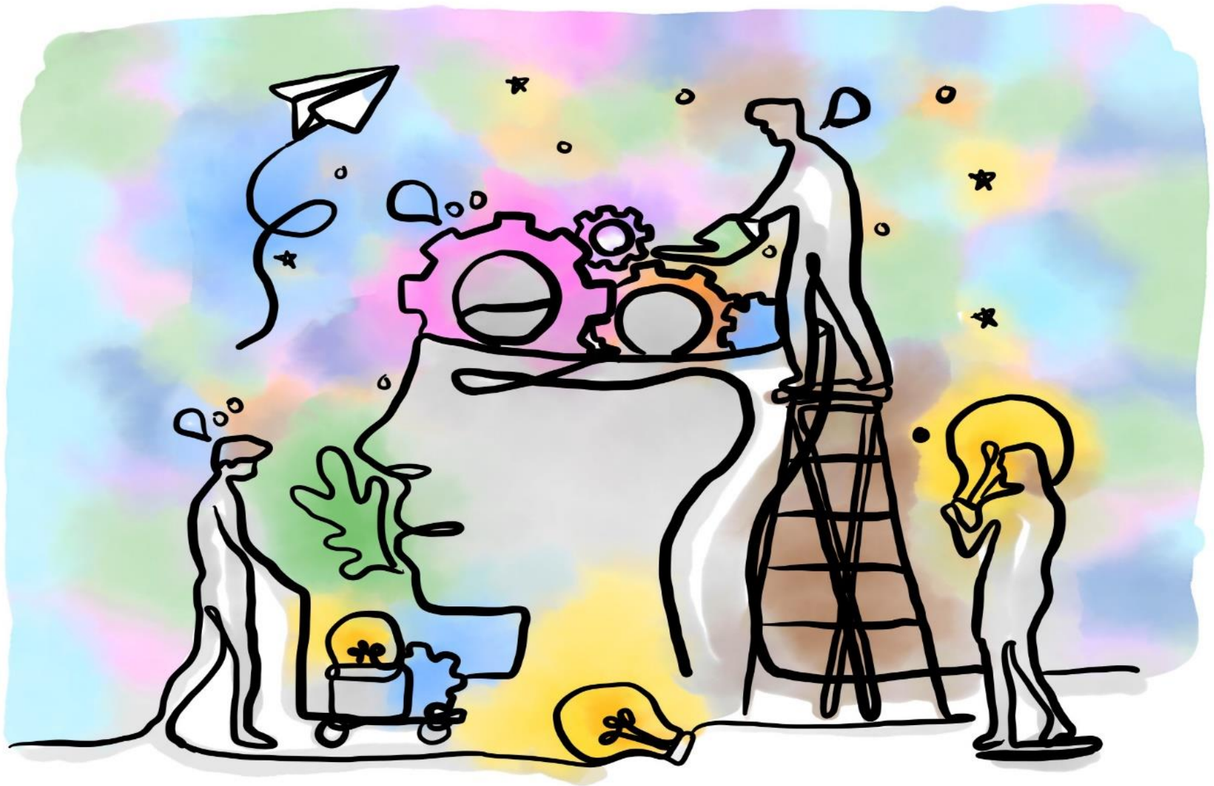


What is ADHD?

Neurodevelopmental condition

Different types: inattentive/hyperactive-impulsive/combination

- inattention and hyperfocus
- impulsivity
- hyperactivity
- **emotional dysregulation**
- excessive mind wandering



Factors behind increase in diagnosis

- Understanding combined presentation **AuDHD**
- Previously thought to be a presentation only in childhood.
- Understanding impact of masking

- Covid

- removal of scaffolding/coping strategies

- General increased awareness – media

@art.by.lorna

Research on autism and suicide

Sussex Partnership NHS Foundation Trust

Large scale Scandinavian studies in 2015 & 2016

Autistic people (without a learning disability) on average die 16 years prematurely.

Suicide was leading cause of premature mortality

9 times more likely to die from suicide than general population

Autistic women 13 times more likely than non-autistic women

40% of those who have attempted suicide had self reported clinically significant autistic traits. **(Richards et al 2019)**

Review of coroners records of suicides found 41% had evidence of autism both diagnosed and undiagnosed. **(Cassidy 2022)**

Why the higher risk of suicide?

Sensory overwhelm - Leads to ‘meltdowns

Masking - Exhausting and can lead to burnout and shutdown.

ADHD - impulsivity/ restlessness

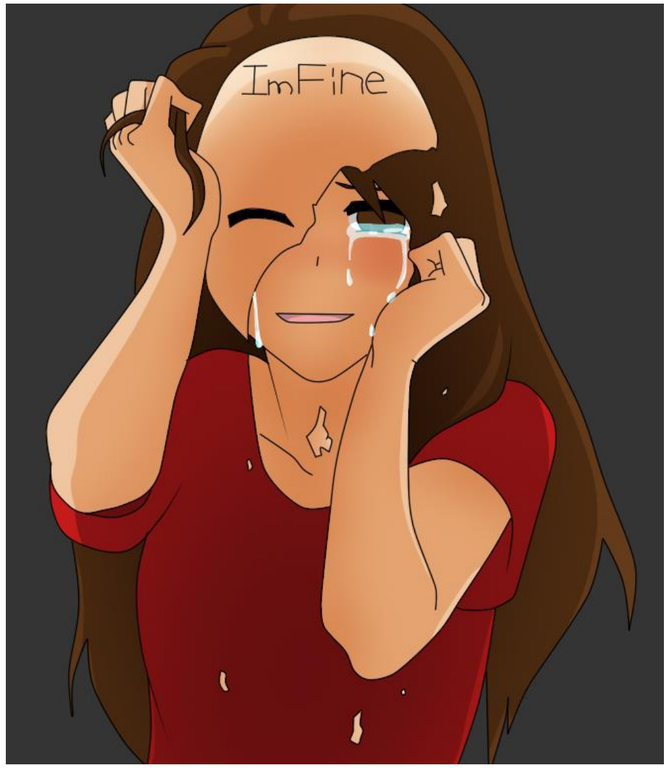
Higher incidence of mental health conditions

Around 70% experience trauma

Executive functioning difficulties

Impact on managing daily life – unidentified need for support/scaffolding

Masking, neurodivergence and suicide – what does this look like and mean what did it mean to me – Emily's story underneath the masks of im fine and im confident



What is some of my story with experiences of neurodiversity and suicide

- Stigma
- Shame
- Secretive
- Distress and meltdowns
- Unable to express myself effectively
- Professionals misunderstanding me
- The importance of hope

Why the higher risk of suicide?

Physical health

Hypermobility – unifying condition with neurodivergence

Unrecognized & misunderstood

Barriers when seeking help

Reasonable adjustments needed – communication & sensory differences.

Alexithymia – may not look outwardly distressed, only notice emotions when v intense

Not getting right support increases feelings of hopelessness.

Intersectionality More likely to face multiple discrimination and disadvantage

More likely not to identify with the gender assigned at birth or have non-binary identity.

People from BAME community less likely to be referred for diagnosis

Socio-economic disadvantage - barriers to employment

What helps keep people well?

Neuroaffirmative post-diagnostic support

Enable positive identity & self esteem

Link with peers

“Unmask” and live as authentic self

Advocate for reasonable adjustments

Develop strategies to navigate the neurotypical world

Sensory strategies

Increase accessibility of services

- Identify and record reasonable adjustments needed
- Consider care act assessment

@ai

Making more environments autism friendly

What helps keep people well?

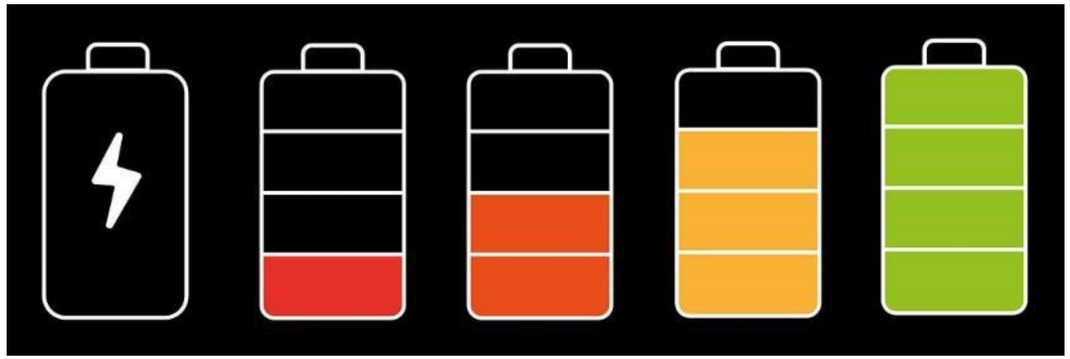
Support with executive functioning

Structure, planners, prompting, Phone apps, PA

Energy accounting

Balance activities that deposit/withdraw energy

Resources for autistic teenagers (autism.org.uk)



Identify support needs in a crisis

Communication, sensory strategies

Sussex autism passport: Information and resources :: Sussex Partnership NHS Foundation Trust

Identify early warning signs

Do not make assumptions as to what may cause distress

These could all tip a neurodivergent person into crisis:

Change

Physical illness

Hormones (puberty, pregnancy, menopause)

Executive dysfunction (organising life)

Injustice

Sensory overload

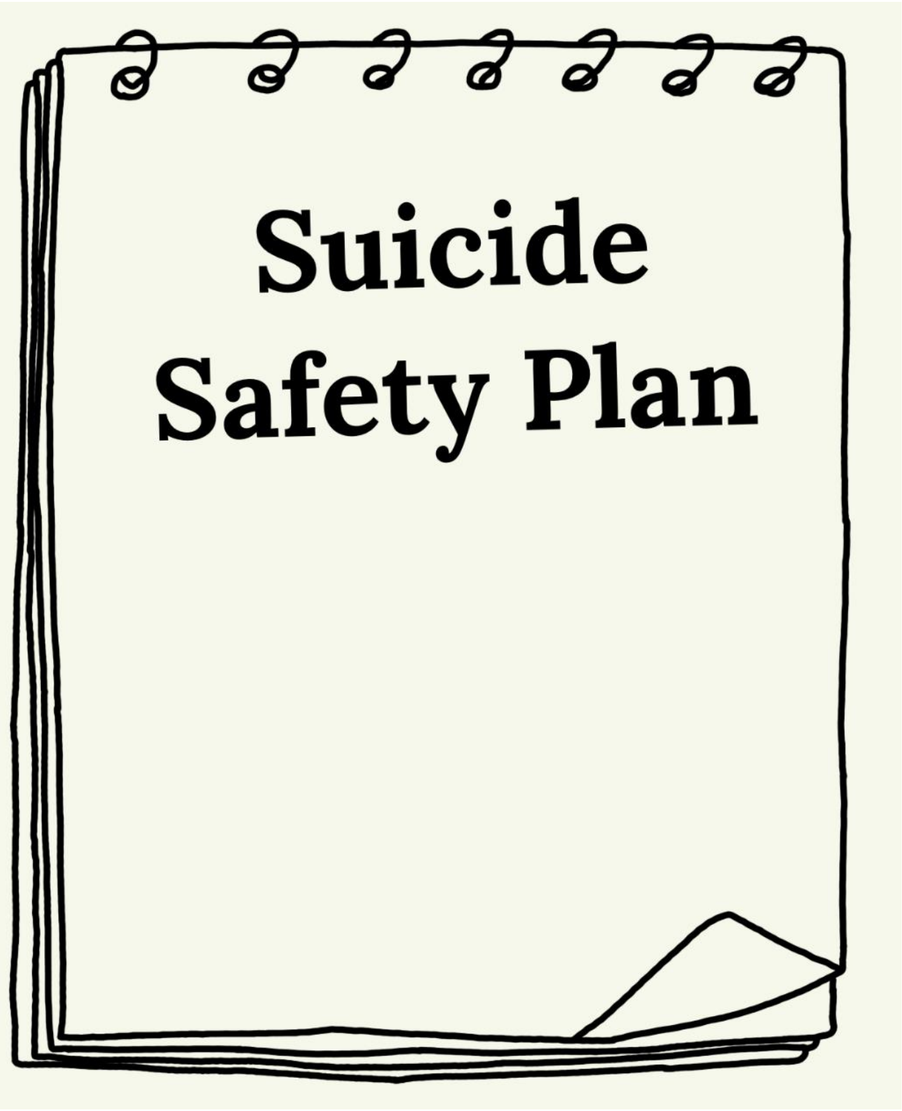
Masking (burnout)

Support to identify individual's warning signs

- What they can notice differently in their body
- What others can notice differently in their behaviour

@art.by.lorna

Emily’s Safety Plan



- **Triggers**
- **What to do if you are struggling**
- **What to do if you are worried that you might not be able to keep yourself safe**
- **Contact numbers of family/friends/ professionals/service im under and where i live**

Autism Adapted Safety Plan

Newcastle University

Sussex Partnership NHS Foundation Trust

- Autism Adapted Safety Plans Link | Neurodevelopment and Disability | Newcastle University (ncl.ac.uk)

Resource pack to support thinking ahead about what might be useful.

Feelings wheel, list of emotions, body map, visual scales.

- **What are my warning signs that I may start to have strong thoughts, feelings or urges to hurt myself and/or end my life? How can other people help support me?**

- How do I communicate distress? *(e.g., I shut down, I have a meltdown)*

- What stresses me/makes me unhappy? *(e.g., loud noises, change of plan, too much information)*

- What can help calm me/makes me happy? *(e.g., a strong interest, stimming, giving me my own space)*

- How would I like you to communicate with me? *(e.g., don't ask me to look you in the eye, use visual supports)*

Considerations in supporting someone in crisis

Sussex Partnership NHS Foundation Trust

- Be aware of alexithymia & masking - don’t assume level of distress or risk from outward facial expression or tone of voice
- Be direct and say one thing at a time.
- Leave space for processing time (minimise competing sound)
- Be aware of environment – can we make it quieter, less bright, reduce smell, give more physical space
- Prompt to use sensory tools - fidget spinner, noise cancelling headphones, sunglasses.
- Be aware of how close you are - ask where person wants you to sit
- Be aware that eye contact can be overwhelming

Emily’s Experience

- **What do you need to come into this environment to feel safe ,engaged grounded, heard, supported, comforted and understood, bring your blank canvas to life .**
- **5 things you can see – i.e. can you see the clock, pictures on the wall, perhaps a table, different colours/lights or views out the window.**
- **4 things you can touch- i.e. can you touch the chair you’re sitting on or the sofa, can your feet touch the floor, can you touch any cushions, can you touch the walls around you**
- **3 things you can hear- i.e. can you hear the clock, can you hear background noise inside and outside of the therapy/other rooms or in the outside environment**
- **2 things you can smell- i.e. can you maybe smell the lavender or the tissues in the tissue box**
- **1 deep breath- how can you feel grounded, present and connected in this space and feel emotions**

Top tips - Communication

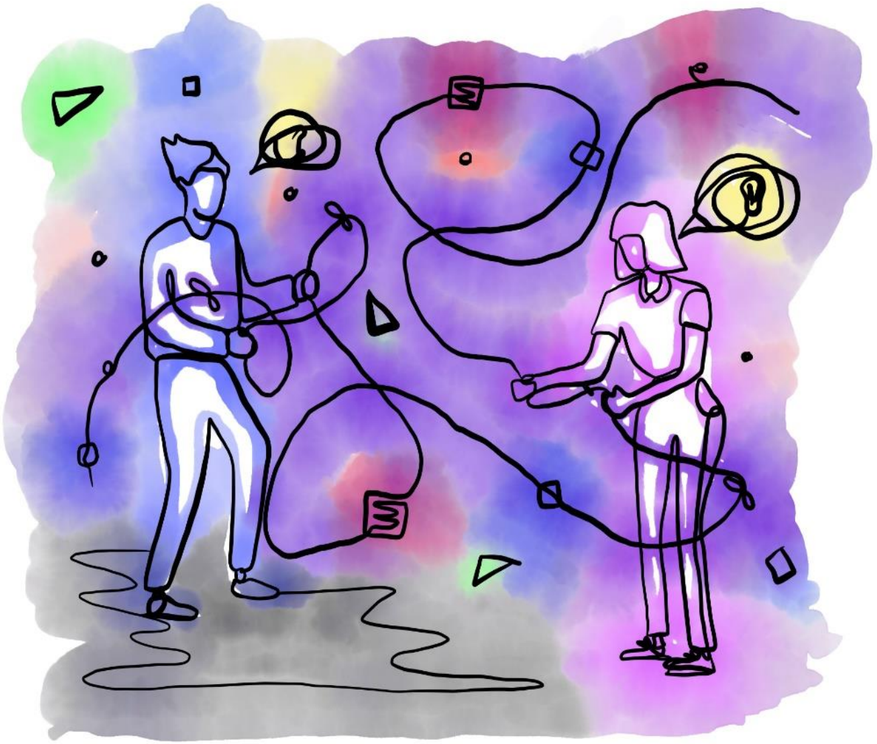
- Don't assume knowledge even if it seems really obvious - explain who you are, why you are there

- If offering choices keep them to a minimum to avoid overwhelm

- Give concrete information about what is going to happen, who, what, where, how long and WHY.

- Avoid sarcasm or jokes that may be taken literally.

- Keep timings realistic, update changes, avoid being specific about timings if may deviate from this.



Emily’s lanyard example

Example of red, yellow and green cards and communication strategies.

NHS Sussex Partnership NHS Foundation Trust

Sussex Police

Brighton & Hove City Council

East Sussex County Council

west sussex county council

NHS Sussex Partnership NHS Foundation Trust

Autism Passport

My name is:

I like to be called:

Date of birth:

Postal address:

Phone number:

My emergency contact is:

Phone number:

In addition to this Autism Passport we encourage you to sign up to the **Pegasus Card Scheme:**

Sussex Police Pegasus Card Scheme is for people who find it hard to communicate with us – we keep your pre-registered information safe on our computer and we can access it quickly if you call us. You don't need to repeat all your details.

Scan here:

NHS
Sussex Partnership
NHS Foundation Trust

About me

How to communicate with me:

Things that cause me distress, including sensory differences:

Things you can do to help me:

Any other important information about me (including medication or health conditions):

NHS
Sussex Partnership
NHS Foundation Trust

Ask me how I am feeling

An autistic person may:

- Avoid eye contact or display minimal or unusual eye contact.
- Behave in an unusual, inappropriate or unpredictable way when anxious, stressed, or confused.
- Find it difficult to cope in new and unfamiliar situations.
- Find it difficult to express emotions, feelings, and needs.
- Find it difficult to know how you are feeling and may seem insensitive, rude, or blunt.
- Not understand consequences of their actions or have no concept of danger.
- Dislike physical contact.
- Misinterpret verbal and non-verbal communications.
- Need extra time to process what is said to them.
- Seem argumentative, stubborn, extremely agitated, or over-compliant.

The Emergency Chat App is free to download. If you can't speak it helps by allowing text communication.

Scan an adjacent QR code:

iPhone:

Android:

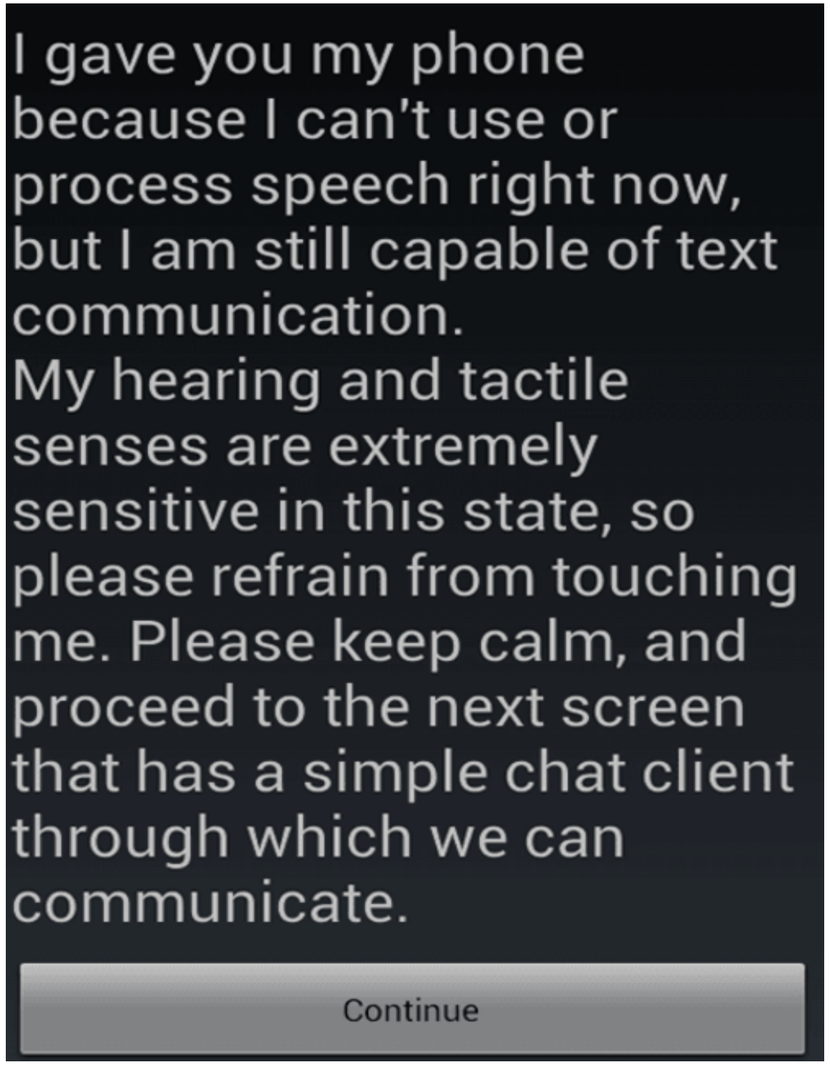
NHS Sussex Partnership NHS Foundation Trust | Sussex Police | Brighton & Hove City Council | East Sussex County Council | West Sussex County Council

NHS Sussex Partnership NHS Foundation Trust

How you can help me

1. Remain **calm**; be patient, tolerant and understanding.
2. **Address me by name** each time you speak to me.
3. When in contact with the police **autistic people are classed as vulnerable**. They are entitled to an 'Appropriate Adult'. This could be my emergency contact from page 1.
4. Be aware your **behaviour and language** can be confusing to me.
5. Keep your language **direct, concise** and **unambiguous**.
6. Use **short**, single clause **sentences** and direct commands.
7. Ask **one question at a time,** and allow extra time for me to respond – **at least 8-10 seconds** before asking more.
8. Autistic people **may have a different understanding of personal space:** standing too close doesn't mean they are being confrontational, and standing at a distance doesn't mean they intend to flee.
9. **Always explain what is happening,** what **will happen** and **why**.
10. Be aware autistic people may carry an object for comfort **to help manage stress & anxiety**; removing it can cause extreme distress. **Only remove it if essential.**
11. **Avoid physical touch** unless essential for safety.
12. Be aware autistic people **may not notice if they are injured**, hungry or thirsty.
13. Autistic people can be sensitive to crowded noisy places, sudden/ loud noises, touch, smell and lighting. **Find the quietest, least busy, place possible;** try to be reassuring.
14. **Avoid sudden and unexpected changes**.
15. Keep timings realistic and update any changes. **Avoid being specific about timings;** you may be taken literally and cause distress if you deviate from the time you have given.

Emergency chat app



Resources

Sussex Partnership NHS Foundation Trust

Autism Adapted Safety Plans Link | Neurodevelopment and Disability | Newcastle University (ncl.ac.uk)

New research and free guide: how to adapt mental health talking therapies for autistic children and adults (autism.org.uk)

Autism passport

NDS Public website resources: Neurodevelopmental services (adult) :: Sussex Partnership NHS Foundation Trust

Interoception - https://youtu.be/A0zbCiakjaA

Training video on suicide and autism

NDS Participation Padlet https://padlet.com/ParticipationTeam/ifepyz61081lymhj

Final quotes - Emily

Hope Recovery AND HEALING

“Rock bottom is often the solid foundation on which we grow, learn and rebuild our lives and come back stronger”

“The bravest thing i ever did was continue to live when I wanted to die”

“ i am brave i am bruised i am who i’m meant to be”

“Look at you, challenging that voice, healing those traumas, addresing the difficult challenges, helping us to help you in your way and finally speaking bravely and vulnerablly.”

“Growth and change gets messy, ugly, painful but then the hope starts to find it’s way through and the light shines brightly, because when your broken and lost on the ground, you will be found, because perhaps the butterfly is proof you go through a great deal of darkness, yet become something beautiful.”

The bravest thing you ever did was continue to live when you wanted to die. Rock bottom is often the solid foundation on which we rebuild our lives. I am brave, I am bruised, I am who I’m meant to be, this is me. Never be ashamed of your story, it will inspire others

Emily

Suicide Prevention Lived Experience Advisory Group member