Suicide Prevention and Community Based Models

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We know that suicide is an important public health issue as over 800 000 people die by suicide each year worldwide and approximately 6000 people per year in the UK. Prevalence of death by suicide among men is consistently higher than females in the majority of countries, however in South Asian populations the rates are higher for women. There are potential lifelong implications of non-suicidal self-harm and suicide attempts, such as an increased frequency of suicide, especially if the behaviours are adopted as a long-term coping strategy. Worryingly, adolescents and young adults are highly vulnerable to finding themselves in a crisis and rates in these groups is increasing for both self-harm and suicide.

The strongest predictor of completed suicide is a history of self-harm and suicide attempts. Both have higher rates in UK ethnic minority groups. With regards to death by suicide and ethnicity in the UK, the data is still unclear. However, due to the disproportionate number of deaths associated with COVID-19 and ethnic minority population, ethnicity is now recorded for deaths. Thus, data may now become more available for suicide and ethnicity, giving us an opportunity to understand more of the predictors within this group. Although suicide attempt are one of the strongest predictors of suicide, it is widely accepted that the psychosocial determinants of suicidal ideation and suicide behaviour are multifactorial and complex. Risk factors include unemployment, living alone, socioeconomic factors, and relationship breakdown including divorce and separation, which pose significantly greater risk for males than for females. Risk factors also include domestic violence, sexuality, loss, grief, and misuse of drugs or alcohol. Problems associated with poor reporting and rates of help-seeking add further complexity to the multi-faced nature of suicide. Around 18-19% of people who die by suicide do not access support from a primary care provider in the year preceding their suicide, with research supporting that people endure proportionally greater mental distress before they engage in help seeking behaviour. Additionally, there is evidence that for those who do communicate suicidal distress, service provision is lacking, particularly within community settings.

Suicide is an avoidable death and those in suicidal crisis should be able to access the relevant support, advice and help needed for them. More importantly, individuals in a suicidal crisis should be made to feel safe, respected, and cared for. Not all self-harm and suicidal crises are because of a mental health need or illness and may have happened due to a build-up of social and psychological stressors. It can be practical issues for some people or emotional supportthat they need. In many cases, a medical response is not needed and support in a suicidal crisis can come from a range of resources. Existing suicide prevention services may be incompatible to the needs and preferences of people who are experiencing suicidal distress. Thus suggesting that suicide prevention interventions should be tailored to suit the specific needs of their targeted audience. For example, men have reported needing support from a trusted individual, preferably in an informal setting; and ethnic minority people may benefit from treatment from therapists who are more culturally aware. Facilitating rapid access to community-based models could overcome problems associated with poor help-seeking behaviours and communication of suicidal distress among vulnerable, high risk groups. It would also offer the desired informal setting which would be a much-needed lifeline to people in suicidal crisis that cannot be provided by conventional primary care or emergency departments. Effective suicide prevention and intervention is therefore vital due to the prevalence of the problem.

Current initiatives addressing suicidal crisis or self-harm focus on mental health crisis in secondary care and are not acknowledging that most self-harm and suicidal crisis occurs within community settings. Most people in suicidal crisis or who may self-harm do not need admitting to hospital. This is really important as many patients have given feedback and highlighted the potential harmful consequences and more long-term negative outcomes they have had due to being admitted to hospital. However, effective alternative services do not seem to exist with community health settings. This issue is heightened within ethnic minority populations who are still hospitalised more than their White counterparts and thus may have worse health outcomes. While patients may contact the National Health Services for suicidal crisis or self-harm, patients usually not likely to be referred for psychological therapies and they may not be referred to a specialist service that treats people in a crisis specifically for these issues. If patients are referred for psychological therapy, waiting lists can be up to many weeks or months. Additionally, a person may not meet the criteria for psychological services if they disclose self-harm or suicidal thoughts; thus leaving limited options for people who may find themselves in a crisis.

New innovative community-based services, using brief interventions to reduce psychological distress and future self-harm or suicidal distress, are being delivered in some localities across the country. In Liverpool two services offer brief psychological interventions. One is James Place which is for men in suicidal crisis and is based within the community. The other is the Hospital Outpatient Psychotherapy Engagement (HOPE) service for people who attend A&E following self-harm. Findings from both services indicate significant outcomes for reduced repetition of self-harm, reduced suicidality and reduced readmission to hospital. Further feedback revealed that people felt listened to for the first time and actually believed that there was hope of them feeling better. Positives from their experience of attending the therapy included not forcing them to stop having suicidal thoughts or self-harming, being able to talk about self-harm and suicidal thoughts in a non-judgemental environment, feeling comfortable as they were allowed to talk openly about suicide and self-harm, and having a therapist who was not shocked or disappointed when they revealed actions or thoughts during the course of the therapy sessions. Sessions were described as uplifting, positive, being taken seriously, having somebody who really wanted to listen and help them work through their crisis or actions, and being treated in a non-clinical environment away from medical settings. Patients revealed other services having left them feeling more distressed due to the negative reaction from staff and being punished through punitive systems as they could not attend if they were still suicidal or self-harming, suggesting what they are doing is wrong.

Community based models that can be accessed by people for suicide prevention at point of crisis is important and could help in reducing suicides. Tailored services to meet the needs of specific community groups would be recommend. However, more research is needed to fully understand how effective suicide prevention services delivered within community settings are.