APPLIED SUICIDE INTERVENTIONS SKILLS TRAINING

ASIST

An Overarching Programme Briefing

Delivered in partnership by

27th January 2013

THE PARTNERSHIP

Common Unity Social Enterprise is a Health and Social Care organisation specialising in working on mental health and wellbeing with 'hard to reach' communities. It was established in 2009 by community activists from BME communities who were also mental health professionals, and who had grown up in the inner city areas of the West Midlands.

Their personal and professional experiences have formed their instincts about, and specific insights into, what works in communication with a wide range of audiences. They help individuals, communities and service providers to overcome barriers to communication and the fulfilment of potential, ensuring that services are both accessible and relevant.

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Forward For Life through its programmes of work looks to provide benefit to communities where marked inequalities in health status are most apparent being recognised as related to social and economic inequalities in society

Established with recognised professional expertise in the areas of the wider public well-being agenda, health and well-being service redesign, mental health promotion, suicide prevention, procurement, commissioning and person centred training design and facilitation, Forward For Life supports the health and social care sector and other associated stakeholders to realise a positive impact on the health and well-being of communities.

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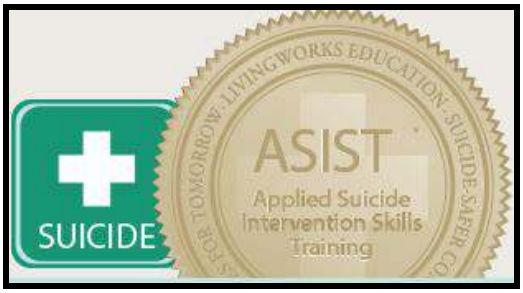
COMMON UNITY AND FORWARD FOR LIFE ARE CERTIFIED ASIST TRAINERS



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THE CHALLENGE

Suicide is a major issue at an international level with there being direct relationships realised between Suicide numbers and health, social and economic inequalities. In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

The suicide rate in the U.K. drastically shot up in 2011, reaching an all-time high since 2004, according to the latest data from the Office for National Statistics. The 8% increase in the number of suicides from 2010 to 2011 highlights the effects that times of financial hardship can have on the public.

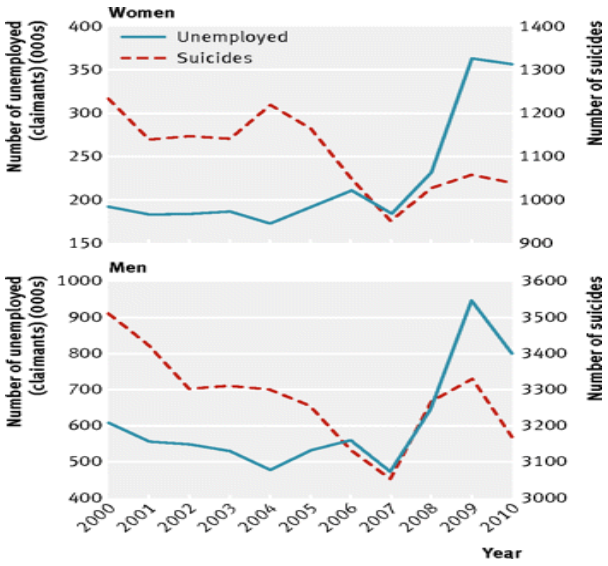
In total, there were 6,045 suicides in 2011 which is 437 more than the previous year, translating into a rise from 11.1 to 11.8 deaths per 100,000 people. The number of male suicides increased in 2011 to 4,552, a rate of 18.2 per 100,000 (the highest it's been in 10 years). Female suicides also increased to 1,493, a rate of 5.6 per 100,000 (the highest rate in 6 years).

The suicide rate was highest among men in their late 30s and early 40s (23.5 deaths per 100,000 population in 2011). Suicide is the second biggest killer among young men globally. A recent study published in The Lancet found that there is a serious lack of research into what prevention techniques are the most effective in preventing suicide.

Preventing suicide in England: A cross-government outcomes strategy to save lives (2012) [i] states

"there are direct links between mental ill health and social factors such as unemployment and debt. Both are risk factors for suicide. Previous periods of high unemployment and/or severe economic problems have been accompanied by increased incidence of mental ill health and higher suicide rates."

A recent British Medical Journal Study[ii] (published August 2012) showed clear evidence linking the recent increase in suicides in England with the financial crisis that began in 2008 for both men and women.



English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men. Recent figures for the West Midlands showed that suicide rates have increased by 24 per cent, with 2007 data recording 245 deaths by suicide/undetermined deaths and the 2010 data showing the number of recorded deaths being recorded as 450.

The *Preventing suicide in England: A cross-government outcomes strategy to save lives (2012)* recognises the value of high quality training and development in a bid to reduce suicide rates stating that interventions that raise suicide awareness or training programmes that teach people how to recognise and respond to the warning signs for suicide in themselves or in others are effective being delivered in a variety of settings including schools, colleges, workplaces and community settings.

THE CONTEXT, THE FACTS & SERVICE AREAS

There are a number of key vulnerable groups that must be engaged either directly or through specific service sectors to realise a reduction in suicide rates – below is an outline of potential support service areas and vulnerable groups:

1) Primary Care Services -

GPs can make a big difference to overall suicide rates. General practices will see a lot of people with many of the known factors for higher risk of suicide, for example long-term physical health problems, self-harming, drug and alcohol misuse and mental health problems. They are the first point of contact for many people who are experiencing distress or suicidal thoughts and who may be vulnerable to suicide. GPs are also the key gatekeepers to specialist services.

Primary care staff may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues.

Health visitors, midwives and other community staff may be in contact with children, young people and families and be the first to be aware of mental health problems or other difficulties developing. They can therefore provide direct support and also refer speedily to other services.

2) Veterinary Surgeons[iii]

There is an increasing body of research to suggest that veterinary surgeons are significantly more likely to die by suicide than those in other healthcare professions and the general population.

3) Farming Community[iv]

It has been suggested that the high risk of suicide in farmers may be related to their ease of access to dangerous means of suicide. Farmers who commit suicide tend to use methods to which they have easy access.

4) Female Nurses

There is evidence[v] from several countries that female nurses are at increased risk of suicide. Very little information is available about the specific causes. Increased risk in nurses has been statistically associated with smoking and negatively related to extent of caffeine consumption. Unlike some other high-risk occupational groups, it is unclear to what extent access to means for suicide contributes to nurses' risk

5) Education Sector[vi]

Suicide consistently ranks as one of the leading causes of death for adolescents between 15 and 19 years of age. Suicide accounts for 30% of deaths in the 15-24 year age group (Carr, 2002). There has been an increase in suicide mortality and morbidity over most of the 20th century among white adolescents in the US and Europe.

Research from around the world has consistently indicated that suicide and suicide attempts in young people are complex behaviours with multiple causes. Studies of youthful suicidal behaviour consistently report that many young people who die by suicide or who make serious suicide attempts have a recognisable psychiatric disorder at the time of their attempt, such as depression, anxiety, conduct disorders and substance misuse.

6) Older People[vii]

Each year across the world, 1 million people take their own lives; in the United Kingdom about 5000 people, many of them over 65 years. In fact, older people are the most successful age group for suicide with about one in four attempts resulting in death. Around two thirds of these suffered from depression and with timely detection and intervention their deaths could have been prevented. Evidence shows that suicide in older people is reasonably well understood; it results from complex social, psychological, biological and spiritual processes.

7) Acute Care Sector[viii]

There is a very strong relationship between deliberate self harm (DSH) and suicide in that between 40% and 60% of people who die by suicide have a history of at least one episode of DSH, and DSH is the strongest risk factor for suicide. Up-to-date information on risk of suicide following DSH is required in order to both target and evaluate suicide prevention initiatives. In recent years in the United Kingdom there have been increases in the extent of DSH. Also, the age, gender and characteristics of both DSH patients and people dying by suicide have changed, with increasing rates in young males.

8) Prisons[ix]

People in prison are unusually susceptible to self-harm and suicide. Male prisoners are five times more likely than men in the general public to die by suicide, while the rate among young offenders is 18 times higher (Fazel *et al*, 2005). Self-harming behaviour is also widespread in prisons, the rates for both genders being higher than in the general population.

9) Police Services

Although it is recognised that many individuals with thoughts of suicide make contact with their GP's in the 3 months prior to taking their own life, studies have shown that police have an even higher contact ratio by the very nature of their job compared to both GP's and accident and emergency – one such study was undertaken in County Durham and Darlington in 2007[x]. In this study a total of 133 suicide verdicts were recorded in a 3-year period; 43 open and 29 accidental death verdicts were included as 'probable' suicides. This gave a total of 205 probable suicides within the 3-year period.

Twenty-four individuals (12%) had had contact with the police within 3 months of death as victims of crime and 24 individuals (12%) had been arrested as alleged perpetrators of crime. Seven individuals had been both a victim of crime and an alleged perpetrator in the 3-month period, leaving an actual total of 41 people (20%) who had been in contact with the police.

10) Armed Forces[xi]

The rate of suicide among those serving in the UK Armed Forces has been reported to be lower than that in the general population and this is likely to reflect a "healthy worker effect" (the phenomenon of lower morbidity or mortality in certain occupational groups compared to the general population because those with severe illness or disability are less likely to be employed in those occupations). A number of studies have examined suicide outcomes in relation to recent conflicts. For example, in the UK, researchers found no differences in suicide mortality between those deployed to the 1990–1991 Gulf War and a matched cohort of individuals who were serving in the Armed Forces but were not deployed.

However, Young men leaving the British armed forces are up to three times more likely to kill themselves than their civilian counterparts, according to a study funded by the Ministry of Defence.

Researchers at the University of Manchester compared UK military discharge records from 1996 to 2005 with national suicide statistics and found that, while the overall suicide rate among ex-military personnel was similar to that of the general population, veterans aged under 24 were at high risk; In fact, they were two to three times more likely to kill themselves than civilian men of the same age. Suicide was most likely within the first two years after discharge, the analysis by the university's centre for suicide prevention found. The risk of suicide was also higher in young women aged under 20 compared with the general population

11) Men[xii]

Masculinities
Masculinity is associated with control, but when men are depressed or in crisis, they can feel out of control. This can propel some men towards suicidal behaviour as a way of regaining control. Men are more likely to use drugs or alcohol in response to distress.

Relationship breakdown
Relationship breakdown is more likely to lead men, rather than women, to suicide. Men rely more on their partners for emotional support and suffer this loss more acutely. Men are more likely to be separated from their children and this plays a role in some men's suicides.

Emotional lives and social disconnectedness
The way men are taught, through childhood, to be 'manly' does not emphasise social and emotional skills. Men can experience a 'big build' of distress, which can culminate in crisis. Men in mid-life are dependent primarily on female partners for emotional support. Women maintain close same-sex relationships across their lives, but men's peer relationships drop away after the age of 30. Women are much more open to talking about emotions than men of all ages and social classes. Men are much less likely than women to have a positive view of counselling or therapy. However, both men and women make use of these services at times of crisis.

Men in their mid-years today

Men currently in their mid-years are the 'buffer' generation – caught between the traditional silent, strong, austere masculinity of their fathers and the more progressive, open and individualistic generation of their sons. They do not know which of these ways of life and masculine cultures to follow. In addition, since the 1970s, several social changes have impacted on personal lives, including rising female employment, increased partnering and de-partnering and solo-living. As a result, men in mid-life are increasingly likely to be living on their own, with little or no experience of coping emotionally or seeking help on their own, and few supportive relationships to fall back on.

12) Socio-Economics

There are systematic socio-economic inequalities in suicide risk.

Socio-economic position can be defined in many ways – by job, class, education, income, or housing.

Whichever indicator is used, people in the lower positions are at higher risk of suicide. As you go down each rung of the social ladder, the risk of suicide increases, even after taking into account underlying mental health problems. There is debate over precisely how low social position increases suicide risk. Suggestions include having many more adverse experiences, powerlessness, stigma and disrespect, social exclusion, poor mental health and unhealthy lifestyles.

27th January 2013

WHAT IS ASIST?

ASIST

Applied Suicide Intervention Skills Training (ASIST) trains frontline staff in early intervention. The 14-hour workshop held over two days teaches participants to connect, understand and assist people who may be at risk of suicide.

The intervention is intended to prevent suicidal thoughts becoming suicidal behaviours. ASIST is underpinned by the idea that many people who are thinking about suicide will find some way to signal their intent. The workshops provide training in suicide intervention and are designed to help a person become more ready, willing, and able to help someone who is having thoughts of suicide.

ASIST is intensive, interactive and practice dominated to help caregivers — or any people of trust — recognise risk and learn how to intervene to prevent the immediate risk of suicide.

It is suitable for mental health professionals, nurses, doctors, pharmacists, teachers, counsellors, youth workers, police and prison staff, school support staff, clergy, community volunteers, and those training to undertake these roles.

ASIST provides standardised, quality assured training that establishes a common language for referrals and is building a network across the UK. This promotes the sharing of peer experiences regionally and nationally. Creating a common language between organisations and community is key to ensuring support, both for people experiencing suicidal thoughts and for those assisting them. ASIST aims to help create clear and lasting community and inter-organisational pathways and networks for understanding and communicating suicide risk and appropriate solutions to preventing it.

WHY ASIST?

Evaluations of ASIST have shown that it is popular with participants and results in changes in knowledge, attitudes and skills. It has also been shown to have an impact in intervention behaviour.

The impact of ASIST on suicidal behaviour has not been evaluated. To assess its impact on national suicide rates would require an extremely large study population. Even if this could be achieved it is widely recognised that the cause of suicide is multi determined and includes complex psychological, sociological and biological factors. It would be difficult to attribute any change in rates to one intervention.

common unity harmony in mind

LivingWorks

Forward for life

ASIST has been implemented in Scotland[xiii] and an evaluation of its use and impact there, based on an internet survey with 534 respondents, concluded that it had been successful in raising awareness of suicide and increasing the body of people with intervention skills

ASIST has been recognised within the most recent evaluation undertaken in Wales[xiv] that *"the roll-out of ASIST the project is making a positive contribution towards suicide prevention within Wales. It is raising awareness and creating a greater understanding and acceptance that prevention of suicide is everybody's business."*

ASIST was developed by LivingWorks in Calgary, Canada, in the early 1980s and since then over one million people in 22 countries have been trained.

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