

Understanding suicide & suicidal behaviour in Northern Ireland

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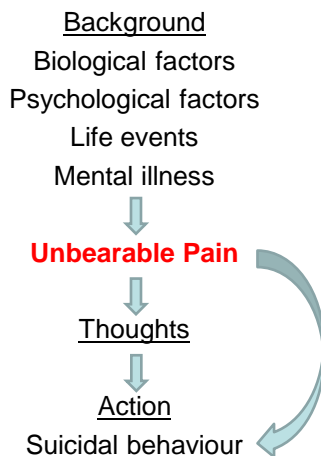
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Some Points About Suicide

- A behavioural outcome, not an illness- but it is associated with mental illness.
- Resulting from combination of social, psychological and biological processes, including capability (ability to carry out the suicidal act).
- Mental illness, previous behaviour, moods, access to means and ability to act are all important factors.
- Alcohol and substances influence all of these.
- Life events are also relevant.
- Suicide prevention needs to address all levels.



Theories of Suicide



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Method: NI Suicide Study

- Data derived from the NI Coroner's office.
- Ethical approval/ Confidentiality agreement.
- Data licence.
- Data collected on 40 variables including:
 - Age, sex, marital status, living arrangements.
 - Pharmacological profile at time of death.
 - Diagnosed physical/mental health conditions.
 - Toxicology.
 - Adverse life events prior to death.



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NI Study of Health & Stress

- Part of the World Mental Health Surveys.
- International studies run by the World Health Organisation.
- Random sample of 4340 representing the whole population (68% response rate).
- Questions about mental health **symptoms** and **experiences**.
- We used the answers to establish whether a person **met the criteria** for a disorder.
- Used a person-centred statistical technique to detect co-occurrences of disorders, life experiences and risk factors.
- Identified “latent” sub groups who share certain characteristics.



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Prior Adverse Events

- No known adverse events 39%.
- Relationship probs 40.3%.
- Death/ grief 12%.
- Health fears 7.9%.
- Financial concerns/ employment crisis 12.9%.
- Disordered substance use 9.7%.
- Alcohol 56% (more males, more younger people).

O'Neill et al (2015) Journal of Crisis Intervention and Suicide Prevention (2015)
O'Neill, Corry, Murphy, Bunting (2014) Journal of Affective Disorders



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Use of Services

- No known mental health problems 31%.
- Disordered substance use 9.7%.
- Withdrawal from service use for males prior to death.
- Increase in service use prior to death in women.
- Men more likely to report only physical health problems (pain).
- Psychological autopsy studies show >95% of those who died had mental disorder.



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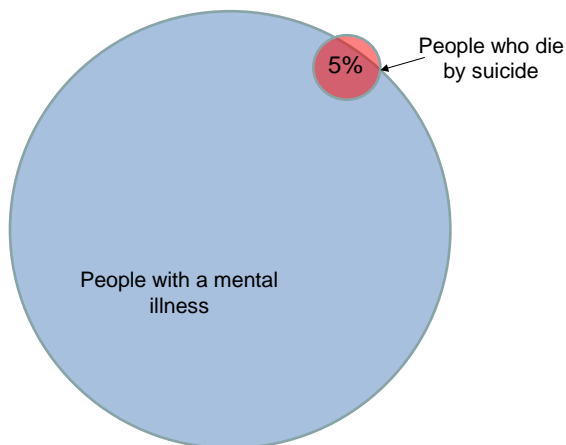
The Northern Ireland Context

- High rates of post-conflict mental disorders.
- Legacy of the conflict: deprivation, hate crime, intolerance, racism (high rates among homosexuals and Irish Travellers).
- Use of alcohol and substances.
- Exposure to trauma.
- Conflict increases connectedness.
- Post conflict: reduced connectedness (especially those who have been most affected).
- Exposure to pain → capability, habituation (less fear/ more expertise).



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Mental Illness and Suicide



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Pain and Suicidal Behaviour

- Suicide is a goal directed behaviour to address unbearable pain.
- Pain + Hopelessness → thoughts of suicide (ideation).
- Connectedness prevents enaction.
- If pain > connectedness → plan.
- Whether this leads to death is dependent upon capability or access to means.
- If total capability > fear of attempting □ attempt.



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Individual Treatment Strategies

- Asking about risk.
- Be wary of “risk assessment”.
- Suicide specific counselling.
- Wraparound/ warm handover.
- Explore options, put decision on hold, safety plan.
- Promoting hope.
- Promoting connectedness (family therapy).
- Coping strategies and problem solving.
- Replacing self harm behaviour.
- Treating mental health disorders.



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Policy Implications 1.

- The average age of those who died was 40 years and the rates of suicide were highest in those aged 20–50 years. Target all age groups.
- The increased proportion of suicides among older women should not be neglected, nor should suicide prevention and mental health interventions for women generally.
- In order to identify the factors predicting deaths among people who self-harm (women), it is necessary to link the suicide and self-harm databases.
- These findings highlight the need for continued vigilance of those who are at risk of suicide and consideration of the ways of restricting access to means.
- Restricting access to information about suicide, such as information from the internet, may influence rates and methods. Media reports should follow established safe reporting guidelines.



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Policy Implications 2.

- Need to address the ways in which people with mental disorders are identified & treated.
- Need to reduce the stigma of mental disorder and recognition of suicidal ideation as indicative of disorder, particularly among males.
- Promotion of help seeking for life events & stress, as well as mental health difficulties.
- Primary care is the main source of services prior to death. These findings add weight to the argument for enhanced screening for suicidal ideation in this setting (NB evidence - risk assessment can be unreliable).
- Important to strengthen clinicians' knowledge of specific manifestations of suicidal ideation which may or may not be identified by service users as related to mental health.
- Examine the capacity of primary care services to provide services to people who are suicidal requires examination; many suicides occur outside of GP surgery hours.



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Policy Implications 3.

- Population alcohol & substance strategies are relevant to suicide prevention.
- Suicide prevention should target those affected by adverse events:
 - Relationship difficulties,
 - Health problems,
 - Financial/ employment difficulties,
 - Death and loss,
 - Traumatic events associated with the Troubles.
- There is a need to direct suicide prevention efforts to those affected by the recession and to be cognisant of the impact of economic and social policies on mental health & suicide rates.
- The maintenance of an accurate, up to date database of suicides is essential to our understanding of suicide in NI, the impact of social, prevention strategies and the rapid identification of trends and patterns.



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