Topic Area - Suicide

Suicide is a devastating event. The consequences of which are felt by family, friends and the community. It is estimated that for every person who commits suicide up to 26 other people will be affected and six of these will experience intense grief reactions. Some of these will themselves be at risk of suicide.

In Warwickshire in 2009 there were 39 suicides (source: ONS Public Health Mortality Files) of whom 13 were known prior to their deaths by mental health services.

86% of people who commit suicide have had contact with a primary care physician in 12 months prior to death and 66% had contact in their last month.
Introduction

Suicide is a devastating event. The consequences of which are felt by family, friends and the community.

A number of national initiatives have been developed to reduce suicide rates. Guidance for the improvement of inpatient mental health care has led to a decrease in the numbers of inpatient suicides by 30%, recommendations for improving media coverage of suicides and legislation on the content of websites promoting suicide hope to bring about a reduction in suicide, especially in adolescents and young adults. Recent reforms to the Coroners service are designed to make the process easier for those bereaved by suicide and aid information sharing so that lessons can be learnt. National campaigns such as Age Concern’s ‘Down, but not out’ and Reach out and C.A.L.M aim to promote mental health and well being, reduce stigma and improve management of vulnerable or high risk groups.

The recent government white paper ‘No Health Without Mental Health’\(^1\) sets out a new approach to mental health in Britain. Key themes include: preventing as well as treating mental health problems, focusing on promotion of mental health and wellbeing, tackling stigma of mental health illness, early intervention, personalized care, multi agency commissioning, innovation, value for money and strengthening transition between children, adolescent services and adult services.

Suicide prevention is one of the seven standards for improving mental health care in the Department of Health National Service Framework for Mental Health (1999)\(^2\). The national strategy is clear that suicide prevention is not the sole responsibility of any one sector, or of health services alone and advocates a broad strategic approach that both targets high risk groups in addition to interventions that improve the well being of the general population and facilitate access to specialist services. This requires co-ordination and collaboration between all public services, the voluntary and private sectors, academic institutions and the concerned individual.

National Perspective

A National Confidential Inquiry \(^3\) found that 26% of suicides, in England, during 1997-2008 were identified as patient suicide, i.e. the person had been in contact with mental health services in the 12 months prior to death. 13% of suicides were inpatients at the time of death. The most common methods of suicide by patients were hanging, self-poisoning (overdose) and jumping/multiple injuries (mainly jumping from a height or being struck by a train).

\(^1\) HM Government (2011) No Health Without Mental Health: Across Governmental Mental Health Outcomes Strategy for People of all Ages.


\(^3\) Suicide and Homicide by People with Mental Illness (2011)
Suicide rates across England are falling and are currently at their lowest rate on record, however over 5,000 people still commit suicide in the UK every year (ICD-10 codes X60-X84 classified as intentional self-harm). On average, a person dies every two hours as a result of suicide accounting for 1% of all deaths in England. It is the leading cause of death in men under 35 and is the main cause of premature death in people with mental illness.

The causes of suicide are complex and multi-factorial. People at higher risk of suicide include young men, those with a mental health illness, those living in poverty, the unemployed, those who misuse drugs and alcohol, those that self-harm, Indian, East African and South Asian women, Irish immigrants and those in contact with the justice system. Life events such as divorce, bereavement and financial problems can be a trigger for those that are vulnerable.

Suicide in the context of serious physical illness has become an increasingly important focus of public attention in recent years as growing numbers of UK citizens with chronic or terminal conditions travel to Dignitas in Switzerland to receive assistance with suicide. Bazalgette et al, 2011 conclude from their survey of PCTs that approximately 10% of suicides, that take place in England, are by a person who is chronically or terminally ill. However, the same survey also suggests that coroners choose not to include relevant health information and thus the number of assisted suicide cases is likely to be higher than records indicate.

A study by the Royal College of Psychiatry found that people bereaved by suicide are between 80% and 300% more likely to commit suicide themselves than the general population.

The Samaritans recognise the public health scale of damage caused by suicides and are committed to taking the lead to reduce numbers. In 2010, Samaritans dialogue contacts, in England, accounted for over 2.7 million contacts, 85.2% of whom made contact via telephone. Over 500,000 callers (20.3% of dialogue contacts) expressed suicidal feelings at the time of the call. This equates to one such call every 57 seconds during 2010.

In the case of email contacts to The Samaritans, in 2010, the proportion expressing suicidal feelings was significantly higher at 42.9% (80,000 emails) at the time of sending and higher still where contact was made via text message 52.2% (87,000 texts).

SANE is a leading mental health charity that recognises the need to improve quality of life in order to reduce suicides. Their staff provide confidential emotional support for anyone affected by mental illness.

In 1999, the Government produced the White Paper ‘Saving Lives: Our Healthier Nation’. It set a target of reducing suicide by 20% by 2010. The National Suicide Prevention Strategy


Self-Harm

Self-harm (often referred to as deliberate self-harm) is intentional self poisoning or injury, irrespective of the apparent purpose of the act.

Levels of self-harm are one indicator of the mental health and well being of young people in our society in general. Self-harm represents one of the most common reasons for hospital presentation of adolescents.

A past history of self-harm is a key risk factor for future self-harm or suicide. Around 40% of suicides have a history of self-harm and at least 1% of people who self-harm take their own lives within a year. Rates of self-harm have been increasing since the mid 1980s. In contrast to suicide, rates are highest in young girls and women - the highest incidence is in 15-19 year olds. In men the highest rates are in 20-29 year olds. The rates are much lower amongst those aged over 50 years. Though the calls are not evidence of actual self-harm incidents, the number of children speaking to ChildLine counsellors about self-harming has grown steadily over recent years. In 2005, more than 5,200 children told ChildLine that they were self-harming and around half of them said they had been cutting themselves. This is a 3% increase on the previous year. Girls were 16 times more likely than boys to call about self-harm.

Many patients who attempt suicide will re-attempt, particularly shortly after discharge from a psychiatric hospital. 50% of those who commit suicide have made at least one previous attempt.

What is happening in Warwickshire?

In Warwickshire, the rate for 1995/97 was 6.33 suicides per 100,000 which was below the average for the West Midlands. The Warwickshire rate fell in the 2007-2009 period to 5.76 per 100,000 – exactly the same rate as for England and almost identical to the West Midlands rate of 5.75 suicides per 100,000 (Source: NCHOD).

Between 2009/10 and 2010/11, there were 979 Warwickshire individuals who attended A&E with a recorded mental health diagnosis who were also coded with poisoning as the primary reason for their attendance. This equates to 7% of all those individuals with a mental and physical condition who attended A&E. We are unable to ascertain the proportion of

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87 ChildLine Annual Review 2005 at www.childline.org.uk
poisonings which were intentional or unintentional. This may be a useful piece of work to be undertaken in the future.

Directly standardised rate of suicides for all persons. 3 year pooled data from 1995-2009

Source: NCHOD

Analysis of suicides that occurred in Warwickshire between 2007/9 (Source: ONS Public Health Mortality Files) found that 76% were males (of whom 51% were under 50 years of age). 10% of all the suicides were in those aged over 80. 63% died by strangulation/hanging and 21% by poisoning/overdose.
Warwickshire suicides by age group and sex 2007-2009

Source: ONS Public Health Mortality Files

Warwickshire Suicides Rate Per 1,000 Population

Source: ONS Public Health Mortality Files
The Warwickshire NHS Suicide Prevention Strategy\textsuperscript{88} takes a broad strategic approach to the prevention of suicide and is designed to encompass a multidisciplinary approach to the prevention of suicide and links in closely with Warwickshire’s Mental Health and Well Being strategy.

The goals and objectives of this strategy are in line with those of the National Suicide Prevention Strategy\textsuperscript{89}.

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<th>Goals</th>
<th>Objective</th>
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| 1. Reduce suicides in high risk groups | 1: Reduce the number of suicides by people who are currently or have recently been in contact with Mental Health Services  
2: Reduce the number of suicides in the year following self-harm  
3: Reduce the number of suicides by young men |
| 2. Promote the mental health and wellbeing of the wider population | 1: Promote the mental health of socially excluded and deprived groups  
2: Promote mental health among people from black and ethnic minority groups  
3: Promote the mental health of people who misuse drugs and/or alcohol.  
4: Promote the mental health of victims and survivors of abuse  
5: Promote mental health in those who are victims of child sexual abuse and domestic violence  
6: Promote mental health among children and young people (ages under 18 years)  
7: Promote mental health among women during and after pregnancy  
8: Promote mental health among older people |
| 3: Reduce the availability and lethality of suicide methods | 1: Identify local hotspots  
2: Continue to audit methods to ensure interventions are tailored appropriately. |
| 4: Improve the reporting of suicidal | |

\textsuperscript{88} NHS Warwickshire suicide prevention Strategy 2009-12

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<th>behaviour in the media</th>
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<td>5: Promote research into suicide and suicide prevention</td>
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<td>6: To improve monitoring of progress towards the Saving Lives: Our Healthier Nation targets for reducing suicide.</td>
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**Services in Warwickshire**

*Safeline* is a Warwickshire based charity who provide individual counselling to relieve suffering amongst people experiencing the after effects of the trauma of rape and sexual abuse. During 2009-10 the charity received 9,400 attempted calls to their helpline of which 1,164 were answered. Over 3,100 counselling sessions were provided to a total of 193 clients across Warwickshire and Coventry.

*Mental Health Matters* is a telephone helpline in Coventry and Warwickshire available to anyone experiencing mental distress can call for help at any time of day, 365 days a year from the confidential service. The service is provided by national charity Mental Health Matters, managed by Coventry and Warwickshire Partnership NHS Trust.
Recommendations from the West Midlands Regional Development Centre

A report produced in 2009 by the West Midlands Regional Development Centre set out a number of recommendations for local approaches to suicide prevention and mental health well being across the West Midlands.

The recommendations were:

- The formation of sub-regional suicide prevention groups. These groups would; work collaboratively on suicide audit, work on identifying and eliminating hotspots, and work across boundaries with media, public transport operators and mental health trusts.

- Mental health commissioners work with public health to improve intelligence regarding the mental health needs of the local population.

- Localities should consider the changing economic situation of the mental health and wellbeing of the local population in order to target services effectively.

- Localities should use number of years of life lost (Y’LL) and disability adjusted life years (DALYs) for mental health and suicide locally to inform policies.

- Suicide prevention plans should not purely focus on those who take their own life, but should provide support for those who are affected by someone who takes their life. This could be done through work place mental health and community based mental well being programs.

- Localities can commission WMPHO to provide data support (such as rates and analysis) to mental health commissioners across the region. WMPHO could also provide further support regarding suicide audit, Y’LLs, DALY’s and hot spot analysis.

- Review commissioners access to PCT suicide data and if this is variable consider developing regional network for analysis of suicide data.

- Consider systems of coding DSH (coding is different in A&E) and look at possibility of auditing this locally.

- Target groups for training should include those working with children and young people in distress (CAMHS), staff who come into contact with young people who self harm, front line staff working with older people with depression and dementia, and primary care staff dealing with people with depression. Support should also be offered to those in professions known to be at high risk of suicide and support for those who come in to contact with victims of suicide such as the police and transport officials.