

SUICIDE AND SUICIDE PREVENTION IN PLYMOUTH

Health and Wellbeing Board 1st October 2015



BACKGROUND

Suicide is a major issue for society and is a leading cause of years of life lost. When someone takes their own life, the effect on their family, friends and colleagues is devastating and many others involved in providing support and care also feel the impact. In England, on average, someone dies every 2 hours as a result of suicide, equating to around 5,000 deaths each year. Suicide is often the end point of a complex pattern of risk factors and distressing events and the prevention of suicide must address this complexity. The estimated overall average cost to society of a case of suicide in England is £1.45 million [at 2009 prices].ⁱ

A death is officially considered a suicide only when a coroner at an inquest has concluded that the person intentionally took their own life. Deaths by undetermined injury are where the coroner at inquest reaches an open or narrative verdict because the intention of the person is uncertain. Both suicide deaths and deaths by undetermined injury are considered in data analysis at national and local levels.

In recent years between 27% and 30% of people who died by suicide were known to have been in contact with mental health services in the 12 months before their death. Thus by far the majority of people who die by suicide are not known to mental health services. Self-harm is one indicator of suicide risk. Some researchⁱⁱ suggests that people who self-harm are 20 times more likely to die by suicide within eight years than those who do not self-harm.

Suicide is the commonest cause of death in men aged <35 years and is the main cause of premature death in people with mental illness. The overall trend in suicide rates in England was decreasing between 1998 until 2008, but has been rising slightly since then. Between 2011 – 2013 the three-year average suicide rate was 8.8 suicides per 100,000 general population.ⁱⁱⁱ The majority of suicides continue to occur in adult males [79% of suicides in 2013]. Suicide rates in men aged 45-54 years have risen by 37% since 2006 and in men aged 55-64 years the rise was 29%.^{iv}

Suicide is not inevitable; in fact most suicides are preventable. Prevention strategies can be effective by:

- Promoting mental and emotional wellbeing and reducing risk factors that can lead to suicidal ideation
- Providing appropriate and effective support and treatment to enable people to continue with their lives and decide not to take their own lives
- Protecting people and keeping them safe through influencing the media, culture, stigma and reducing the availability and lethality of suicide methods

NATIONAL CONTEXT

In 2012, the Coalition Government launched “Preventing suicide in England; a cross-government outcomes strategy to save lives”. The overall objectives of the strategy are;

- To reduce the suicide rate in the general population in England
- To better support those bereaved or affected by suicide

The national strategy identified 6 key areas for action to support the delivery of these objectives and the key areas are;

- Reduce the risk of suicide in key high-risk groups
[Young and middle-aged men; People in care of mental health services; People with a history of self-harm; People in contact with the criminal justice system; Specific occupational groups – doctors, nurses, veterinary workers, farmers and agricultural workers]
- Tailor approaches to improve mental health in specific groups
[Children and young people including looked after children, care leavers and those in contact with criminal justice system; Survivors of abuse or violence; Veterans; People living with long-term physical health conditions; People with untreated depression; People who are especially vulnerable due to social and economic circumstances; People who misuse drugs or alcohol; Lesbian, gay, bisexual and transgender people; Black, Asian and minority ethnic groups and asylum seekers]
- Reduce access to means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

There have been two annual reports since the launch of the strategy documenting current trends in suicide, new messages from research, progress on prevention and making further recommendations for action. The All Party Parliamentary Group Report on Local Suicide Plans in England [2015] considers 3 main elements are essential to local implementation of the national strategy;

- Carrying out a local suicide audit to build understanding of local factors
- Developing a suicide prevention action plan based on the national strategy and local data to reduce the suicide risk in the local community
- Establish a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations

Public Health England have published guidance for local authorities on the development of local action plans and recommends that local plan include

- Monitoring data, trends and hot spots
- Engaging with local media
- Working with transport to map hot spots
- Working on local priorities to improve mental health

Public Health England are piloting a “real-time” surveillance of suicides in collaboration with the police. The primary aim of the pilot is to provide information to front line local authority and NHS staff to enable them to respond to local clusters of suicides and to provide timely support to people bereaved by suicide.

National data on suicide is provided by ONS in their Annual Mortality Extract. Further data is provided in the Annual Report of the National Confidential Inquiry into suicide and homicide by people with mental illness. The Public Health Outcomes Framework includes measures for suicides and self-harm and Public Health England has recently launched a new dataset in their Suicide Prevention Profiles. This data is available down to local authority area level and a current extract is attached as Appendix I.

Trends and learning from national context where numbers mean can be assured of evidence [small numbers in any one area make this difficult]

REGIONAL CONTEXT

Rates of suicide in the South West rates tend to be above national average for England. The age-standardised three-year average rate of suicide 2011-2013 for the South West Region was 10.1 per 100,000 general population.

In July 2014 the South West Strategic Clinical Network for Mental Health started working on bringing together a collaborative of organisations to share a vision of reducing suicides in the South West to zero by October 2018. Through collaborative working, organisations from across the region and different sectors have been working with people with lived experience of suicide to understand what improvements need to be made, identify suitable improvement projects and coming together to learn and share experience. The collaborative recognises that the vision is an aspirational one and will be hard to achieve but is worthwhile, compelling and inspiring.

LOCAL CONTEXT

Local authorities are the lead agencies for suicide prevention and the leadership responsibility most often sits with the Director of Public Health and their team. The complexity of risk factors for suicide means however that many local agencies are required to be involved in local suicide prevention activity.

In Plymouth the Office of the Director of Public Health conducts an annual suicide audit and produces a summary as part of the Joint Strategic Needs Assessment. The latest summary for 2010-2012 is attached as Appendix 2. The general approach taken in producing the audit is that outlined in the National Institute for Mental Health in England document Suicide Audit in Primary Care Trust Localities [2006]. The audit process covers the deaths of Plymouth residents only and those aged 15 or over. The process includes identifying deaths from suicide and also open verdicts from the weekly deaths register, then visiting the coroner's office to find information. Information is also requested from GPs, mental health services and hospitals as required. A record of all deaths during the year is kept and then checked against the annual death extract data when available. The suicide audit undertaken by ODPH looks back in time and gathers information to confirm numbers, causes and other pertinent information. In the 3 year period 2011 – 2013 84 Plymouth residents died by suicide or undetermined injury. The suicide rate in Plymouth 2010 – 2012 was 10.8 deaths per 100,000 population which was above national and regional average values.

The local authority audit is not the only suicide audit that takes place. Mental health service providers and others conduct their own audits, including of attempted suicide and self-harm, which provide additional local data to inform service design and improvement and the prevention agenda.

In response to the national strategy launched in 2012, a local suicide prevention steering group was formed and convened by Public Health. This group was originally made up of those individuals and agencies who were interested in working towards a local approach for the national strategy and has developed over time into a functioning steering group with well-developed relationships. The group has developed an action plan to deliver locally appropriate actions to meet the ambitions of the national strategy. There is a focus in the group on sharing information to identify local issues and solutions where possible. As well as considering suicide data and suicide prevention, the group also consider self-harm. Current members include ODPH, Plymouth City Council Cooperative Commissioning, NEW Devon CCG, Plymouth Community Healthcare [CAMHS, Options, Mental Health Services, Training, Livewell], Police, Age Concern, CASS, Samaritans, MIND, University of Plymouth, The Zone. Plymouth Hospitals Trust and the Coroner's office are included in all of the group's correspondence but have not been able to attend group meetings in the last year. The latest action plan is attached as Appendix 3.

The make-up of the group and the action plan meet the recommendations made by Public Health England on local suicide prevention and plans. The local work as outlined above also delivers the 3 recommended elements outlined by the All Party Parliamentary Group on suicide and self-harm

APPENDICES

Appendix 1 South West Region Suicide Prevention Profile Extract

Appendix 2 Plymouth Suicide Audit Summary 2010 – 2012

Appendix 3 Plymouth Suicide Prevention Action Plan

ⁱ Knapp M, McDaid M and Parsonage M. PSSRU London [2011] Mental Health Promotion and Mental Illness Prevention – the economic case

ⁱⁱ Hawton and Fagg [2008] Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital

ⁱⁱⁱ Dept of Health [2015] Statistical update on suicide

^{iv} University of Manchester [2015] National confidential inquiry into suicide and homicide by people with mental illness. Annual Report for England, Northern Ireland, Scotland and Wales.