NHS
Herefordshire
Clinical Commissioning Group

Chapter 10: Suicide

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Contents

Chapter 10: Suicide

10.1. Introduction and Definition

Suicide is a devastating event with far-reaching consequences. Each suicide represents both an individual tragedy and a loss to society. The factors associated with it are complex and varied.

Suicide can be described as a fatal act of self-harm initiated with the intention of ending one's own life. Although often seen as impulsive, it may be associated with years of suicidal behaviour including suicidal ideation or acts of deliberate self-harm[i]. Suicide is the leading cause of years of life lost in England after accidents.

10.2. Risk Factors

In 2012, HM Government produced a cross Government Strategy on Preventing Suicide in England[ii]. This identified a number of interrelated factors as increasing risk of suicide:

- Previous suicide attempt or previous self-harm.
- Male gender
- Age Concurrent mental disorders or previous psychiatric treatment.
- Homelessness
- Alcohol and drug abuse
- Physically disabling or painful illness, including chronic pain
- Low social support/living alone
- Significant life events - bereavement, family breakdown
- Institutionalised – e.g. prisons, army
- Bullying

Certain professions have a higher than average rate of suicide, although unpicking this may be confounded by poor recording of occupation on death certificates and coroners reports. Historically, it was those occupations with the means/knowledge to kill themselves (vets, doctors, dentists, pharmacists, farmers) that had the highest rates of suicide[iii]. More recently, rates in these professions have reduced significantly and higher numbers of suicides are seen amongst manual occupations such as construction workers and plant/machine operatives[iv].

Individuals with existing mental health disorders are of particular risk of suicide. A review of 15 years of confidential enquiries into suicide in the UK, published in 2011[v], found that the risk of suicide in patients with mental disorders is 5-15 times higher than that for patients without co-existent mental disorders. A quarter of people who commit suicide have been in contact with mental health services, with risk of suicide increasing following discharge from mental health wards.

10.3. Preventing Suicide

Whilst each suicide represents a personal tragedy, it also impacts individuals' families and communities.

In addition to the immense pain and grief that a completed suicide produces, there are also implications in terms of direct costs to police, funeral and healthcare services, amounting to some Euros 2million in European countries[vi]. Suicide prevention therefore is both morally urgent and cost effective.

In addition to the National Suicide Prevention Strategy, a number of national activities have been shown as effective in reducing rates of suicide. These include the withdrawal of the analgesic co-proxamol[vii], reduction in pack sizes of paracetamol and adoption of "safe by design" approaches for psychiatric wards[viii] and structures such as bridges and car parks[ix].

On a local level, commissioners may contribute to the prevention of suicide through commissioning of mental health services that:

- support staff training around suicide and self harm
- are compliant with the National Confidential Review
- provide 24-hour crisis services;
- support patients with (and have a policy regarding) dual diagnosis
- undertake multidisciplinary reviews after suicide[x]
- provide support (including CBT) for individuals who self harm[xi]
- provide support (including pharmacological support) for people (including the elderly) with depression[xii]

McDaid et al (2010) indicate that a 20% reduction in the number of suicides, equating to an average of three per year in Herefordshire, would pay for the activity under the National Suicide Prevention Strategy in terms of deaths avoided and quality adjusted years of life gained.

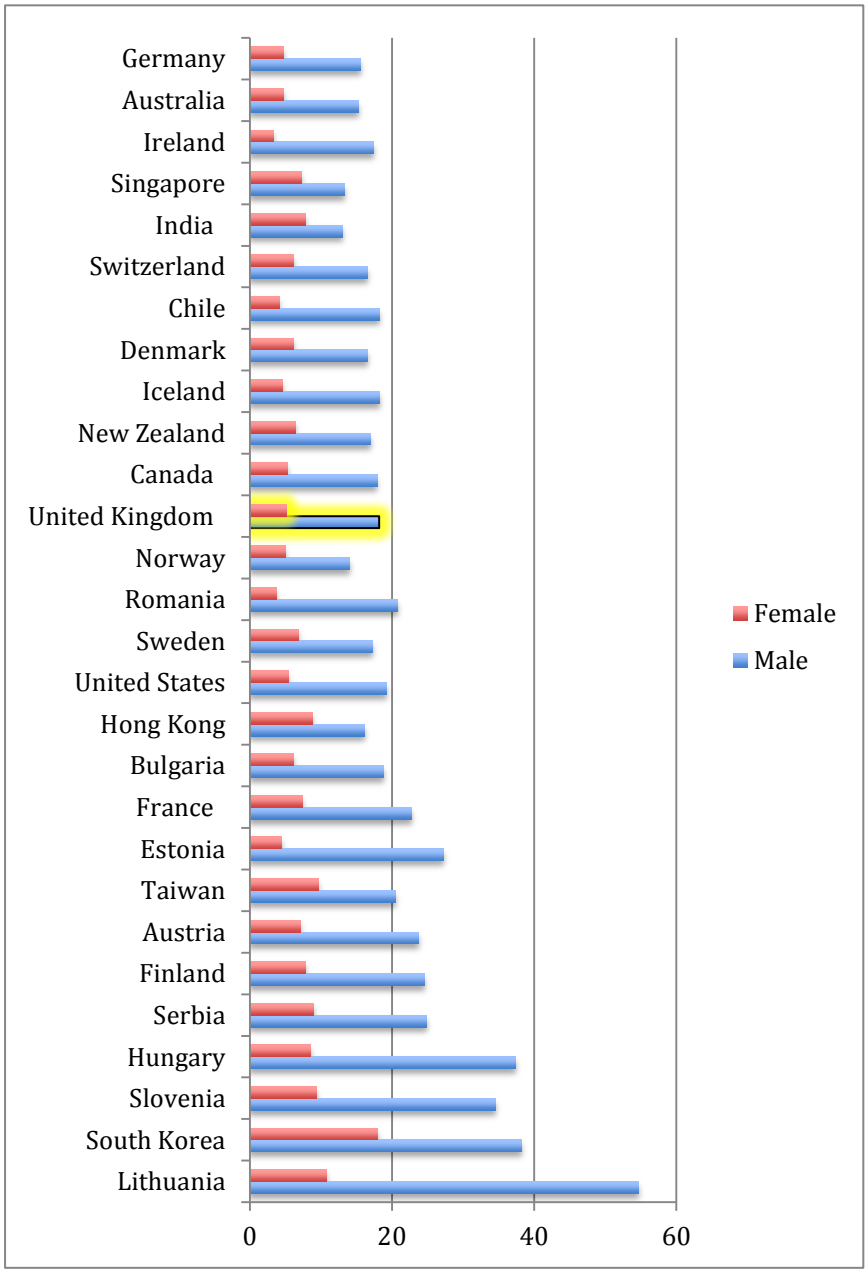
10.4. Routine Suicide Data

Data on suicide is collected nationally and internationally via coroner's records following an inquest. Due to cultural and economic reasons, such records are unreliable. In the UK all homicides and suicides committed by people in contact with mental health services (in the past 12 months) are investigated as part of the National Confidential Enquiry into Suicide and Homicide.

10.4.1. International Comparisons

The World Health Organisation has collated records on suicide notifications[xiii]. The UK is 33rd of 105 countries in terms of rates of recorded suicides per 100,000 people (See Figure 10.1). There are likely to be significant issues in terms of recording between countries. Variation in rates of suicide between countries are most likely due to a combination of factors, including levels of alcohol misuse, the lethality of commonly used methods of suicide, economic prosperity, religious and cultural attitudes towards suicide, and access to treatment.

Figure 10.1: Rates of Suicide per 100,000 people



Source: WHO, Country reports on Suicide (2014)

10.4.2. National Comparisons

The latest national figures for suicide in the UK are for 2012, with a time series covering 1981 to 2011 to allow comparisons to be made.

In 2012, there were 4507 suicides in the UK in people over the age of 15. This equates to 10.4 deaths per 100,000 of the population.

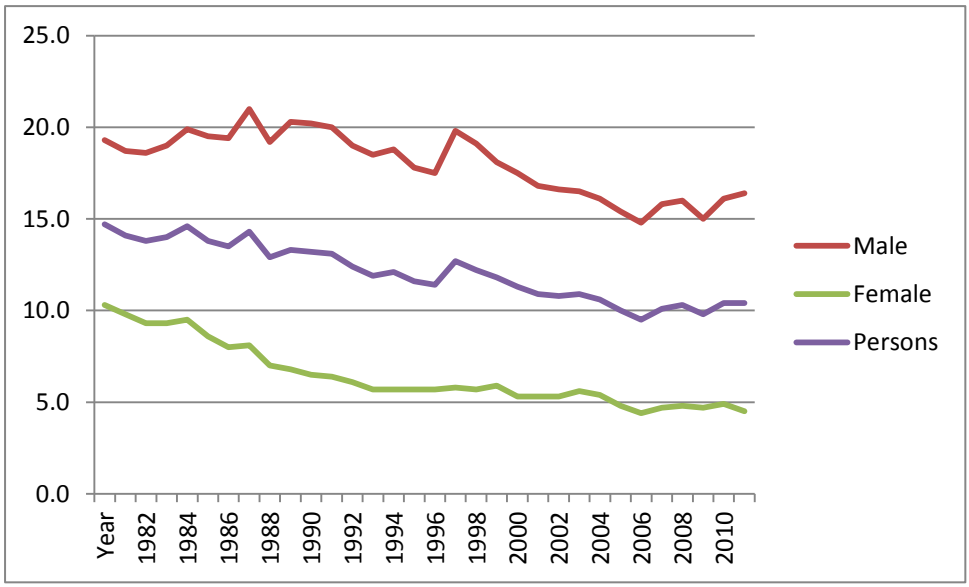
Men are three times more likely to commit suicide. In 2012 in the UK there were 18.2 male deaths per 100,000 population, and 5.2 female deaths per 100,000 in the UK. With the highest suicide rate is in men aged 40-44. In this group there were 25.9 deaths per 100,000 population.

Suicide rates have fallen since the 1980s, although this decline has not been consistent, with significant increases in 1989-90, 1997-98 and 2010-11.

The most common methods of suicide in the UK in 2012 were hanging, strangulation and suffocation (58% of male suicides and 36% of female suicides) and poisoning (43% of female suicides and 20% of male suicides). There has been a year-on-year rise in suicides by helium gas inhalation over the last 5 years[xiv].

High-risk groups for suicide include men aged 35-54 years and people who have self-harmed, have depression, misuse alcohol, are facing economic difficulties, are going through divorce or separation, or have long-term physical illnesses[xv].

Figure 10.2: Age Standardised Rates of Suicide per 100,000 persons in England (1981-2012)

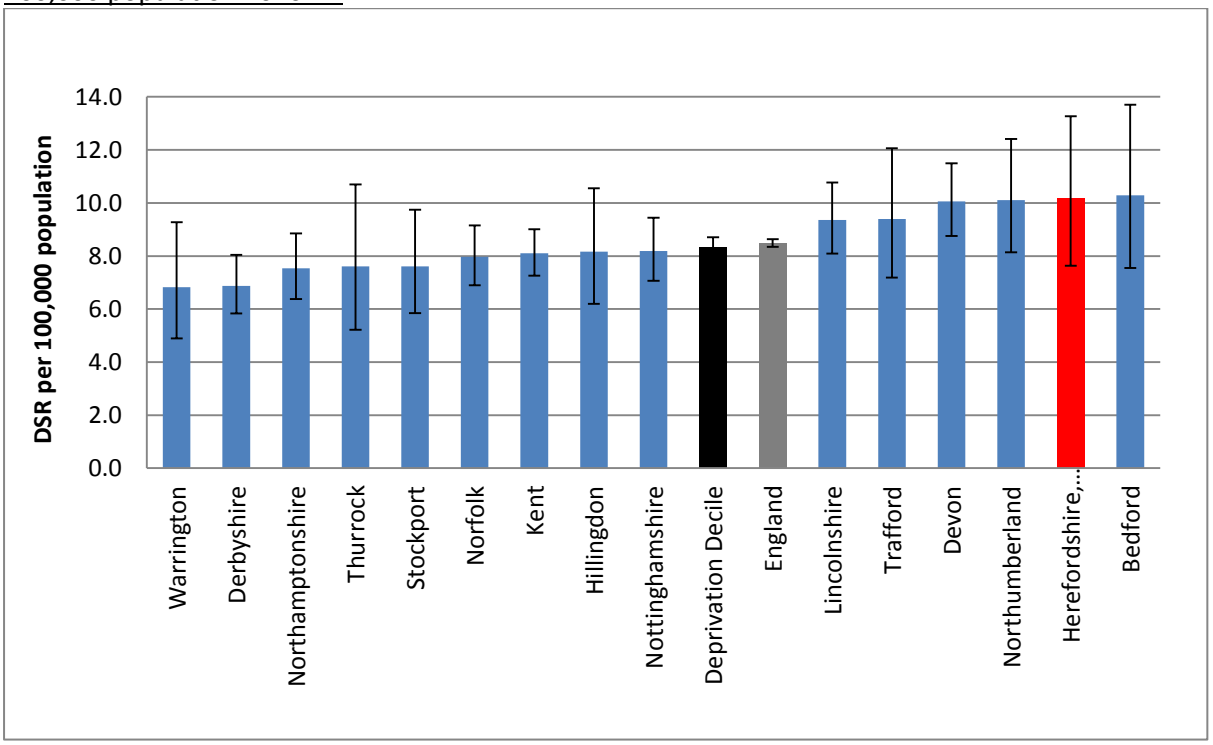


Source: ONS (2013)

10.4.3. Local Incidence

National comparable data for Herefordshire can viewed via the Public Health Outcomes Framework[xvi], pooling data from 2010 to 2013. These figures combine both suicide and deaths from injury of undetermined intent.

Figure 10.3: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population 2010-12



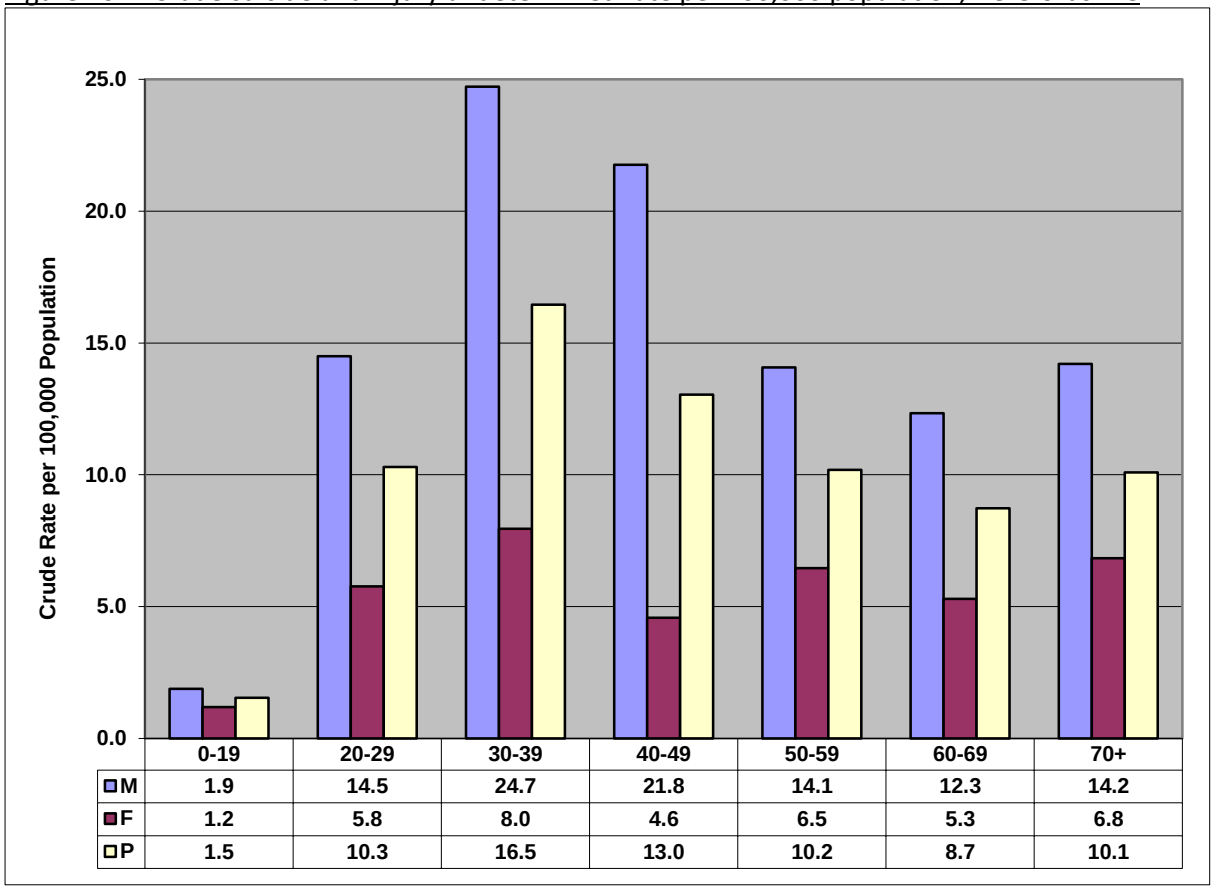
Source: Public Health Outcomes Framework (2013)

Within this data set, England has an age standardised mortality rate from suicide and injury of undetermined intent of 8.5 per 100,000. Herefordshire has a rate of 10.2 per 100,000 population. However, due to the low numbers of events and Herefordshire's relatively small population size, this is not significantly different from national or average deprivation decile rates.

Reflecting national rates outlined above, men in Herefordshire have higher rates of death from suicide and injury of unknown intent in compared to women, with men comprising over 70% of related deaths.

In contrast to the figures above, deaths by suicide and injury of unknown intent in Herefordshire peak for both men and women in the age band 30-39 years.

Figure 10.4: Crude suicide and injury undetermined rate per 100,000 population, Herefordshire

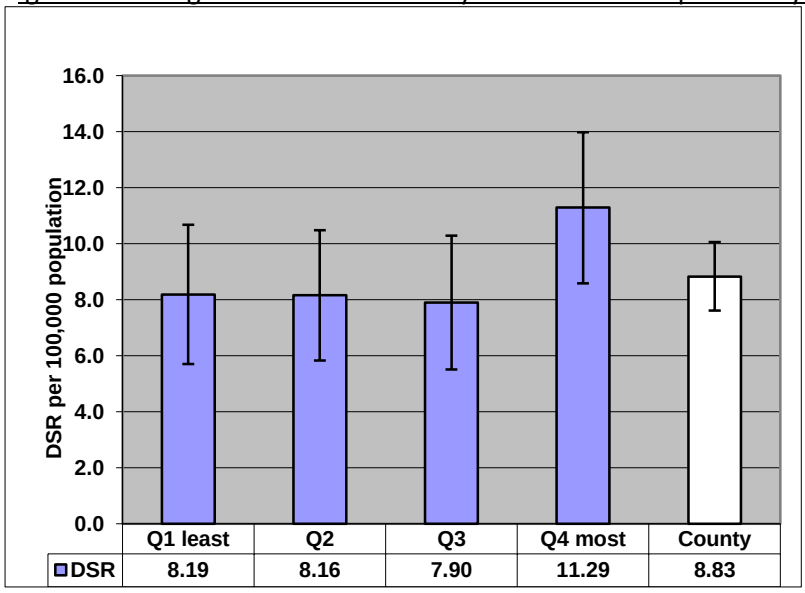


	0-19	20-29	30-39	40-49	50-59	60-69	70+
M	1.9	14.5	24.7	21.8	14.1	12.3	14.2
F	1.2	5.8	8.0	4.6	6.5	5.3	6.8
P	1.5	10.3	16.5	13.0	10.2	8.7	10.1

Source: ONS (2013)

The distribution of death by suicide and injury of unknown intent within Herefordshire is also seen to be influenced by deprivation, with the highest rates occurring in the most deprived quartile, although this is not statistically different to the county average (figure 10.5)

Figure 10.5: Figure: Suicide Mortality Rates 2001-13 pooled by Deprivation Quartile (IMD2010)



	Q1 least	Q2	Q3	Q4 most	County
DSR	8.19	8.16	7.90	11.29	8.83

Source: ONS (2013)

10.5. Local Suicide Audit

Given the lack of detailed data reported on a national level for local suicides, a local suicide audit was undertaken in August and September 2014. Coroners reports were obtained and reviewed for the period 1994-2014, giving a 20-year data set of all deaths confirmed by inquest as resulting from suicide.

Data was extracted for sex, address, place, date and mode of death occupation and marital status to identify trends over time. A second phase is planned following October 2014, reviewing patient medical records (GP and mental health secondary care) and national confidential enquiry records for the period 2008-13, to identify if cases had contact with GP and/or mental health services prior to their deaths.

10.5.1. Results Summary

- There were a total of 300 recorded suicides in Herefordshire between 1994 and 2004, an average of 15 suicides per year.
- Peaks in suicide incidence occurred in 2006 (22 suicides), 2001 (20 suicides) and 1995 (16 suicides).
- The lowest number of suicides was recorded in 2003 (11 suicides)
- The variability in rate may reflect a number of interconnected issues relating to the economy, employment and service provision such as the availability of psychiatric and social services.
- As with national data, men in Herefordshire are nearly 3 times more likely to take their own lives as women.
- The peak in recorded suicides in the 70+ age group demands further investigation. It should be noted that these figures are not age standardised and some of the increase in this age group may reflect Herefordshire's age profile, which is older than the national average.
- The proportion of persons recorded as "single" may be a coding issue and may not reflect current or historical levels of cohabitation. However, social isolation is a contributory factor in mental health and a taken as a group, the categories "Divorced" "Separated", Widowed" and "Single", representing two thirds of suicides, are suggestive of individuals living alone. This may guide future targeting of preventative work.
- The predominance of agricultural professions is not unexpected given the high profile of rural suicides and the importance of farming and allied industries to Herefordshire's economy. It does however suggest that further targeted work is required in meeting the mental health needs of Herefordshire residents in rural areas.
- The frequency of suicide in the construction industry may also reflect employment profiles within the county, but likewise points towards opportunities for targeting mental health interventions at men employed in construction.

- The data suggests heightened risk of suicide in persons who are unemployed and/or housewives.
- The most frequent means of suicide was death by hanging or asphyxiation. That men choose more violent methods of suicide and women are more likely to use poison or overdose is well documented, although may support future programming.
- The paucity of recording of means of poisoning prevents conclusions being drawn regarding medicines management etc. and should be addressed in future reporting.
- Men aged over seventy are more than 2.4 times more likely to commit suicide using a firearm than younger men. This figure is statistically significant at the 95% level.
- Contact with clinical services is poorly recorded and should be addressed.

10.5.2. Total Number

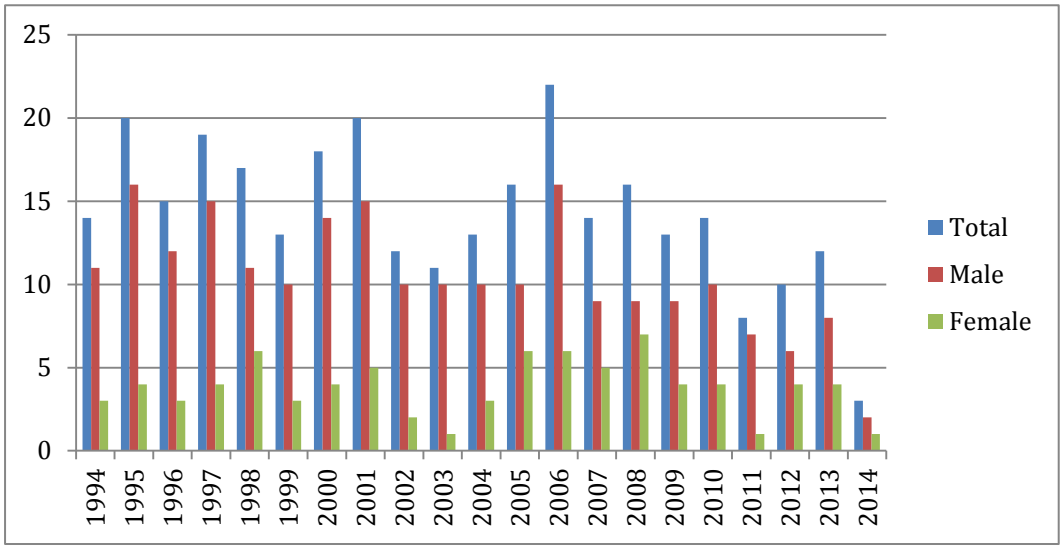
There were total of 306 suicide record found and noted, out of which 5 were deleted because of no other records apart from names. In addition, one record was deleted because of error in the year of death (was recorded as 2017), leaving a total of 300 recorded suicides between 1994 and 2013-2014. It should be noted that due to the lag in receiving notifications of inquest, the year 2014 was incomplete.

10.5.3. Number of Suicides by Year

From the above figure of 300 suicides between 1994 and 2014, Herefordshire experienced approximately 15 suicides per year over the preceding twenty years. However, as can be seen in figure 10.6 below, the number of suicides varied markedly over time, with notable peaks in 2006 (22 suicides), 2001 (20 suicides) and 1995 (16 suicides).

Small numbers in 2014 can be explained by incompleteness of the data record and delay in suicide notifications, however, the low figures for 2011 (8 suicides) and 2012 (10 suicides) may be suggestive that national and local efforts to reduce suicide are showing results.

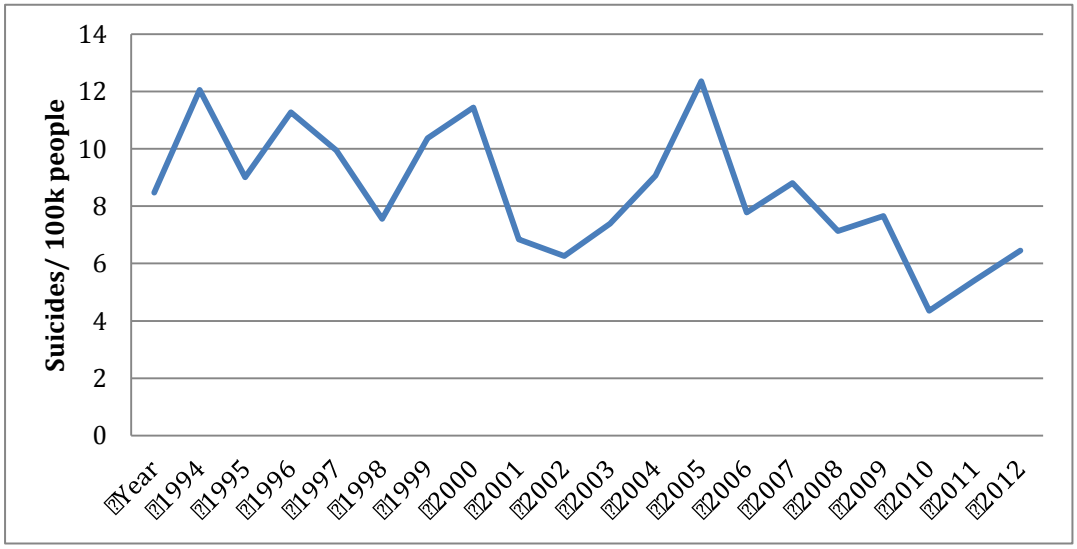
Figure 10.6: Numbers of Suicide Per year in Herefordshire by Sex



10.5.4. Suicide Rates

Figure 10.7 shows the rate of suicides per 100, 1000 people in Herefordshire between 1994 and 2013. This graph shows an overall decreasing trend in rates of suicide in the county, reflecting the national trend shown in Figure 10.2. A notable reduction in rate is seen in the data around 2002/3 to approximately 6.8 suicides/100,000 people, with a peak in 2006 of approximately 12.3 suicides / 100,000 people.

Figure 10.7: Rates of Suicide per 100,000 people in Herefordshire, 1994-2014



The reduction in rate between 2002 and 2003 does not match that shown nationally and recording error cannot be discounted.

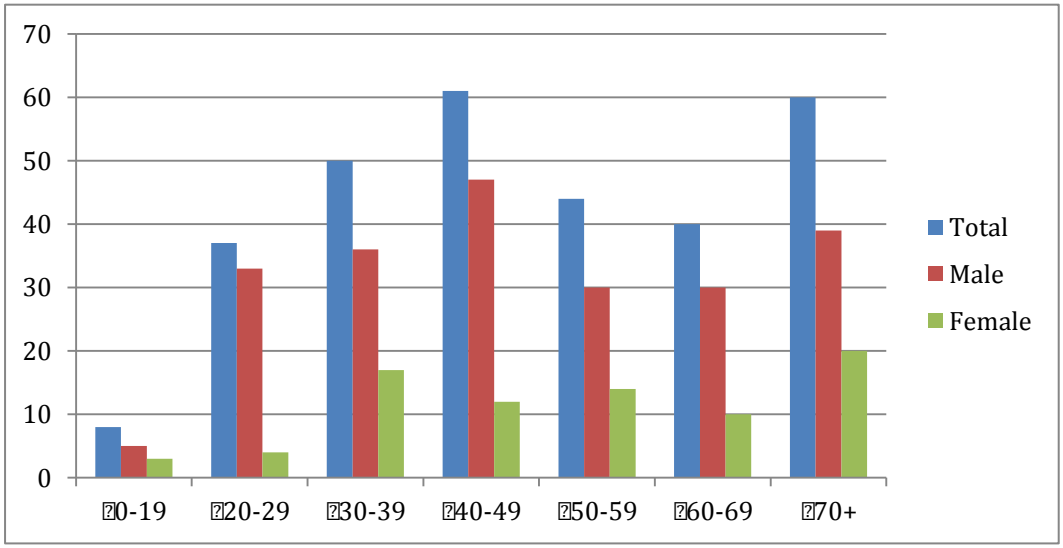
It should be noted that the rate of suicide per 100,000 people during the period of 2008-2010 is 7.86, below the 7.9 national average used as a benchmark under the National Suicide Prevention strategy.

10.5.5. Suicides by Age and Sex

Reflecting national data, men were 2.75 times more likely to be recorded as having committed suicide than women (men=220 suicides, women=80 suicides). However, in contrast to national data, the highest number of suicides in men occurred in the age band 40-49 years (compared to 30-39 years in the national data), with the highest number of suicides in women occurring in the 70+ category (compared to 30-39 years nationally).

Figure 10.8 shows that the 70+ age category has the second highest frequency of suicides with 60 suicides recorded in this age group between 1994 and 2014 (39 men and 21 women). This is not reflected in the national data and suggests that persons in Herefordshire aged over 70 years are more at risk of suicide (or more likely to have cause of death recorded as suicide) than their peers nationally. People aged over 70 represent (55/300=) 18% of the suicides in Herefordshire between 1994 and 2014. For reference, people aged 70 or older represent (27600/183500=) 15% of Herefordshire's population. It is not possible to compare to the national figures to identify if this increase is statistically significant.

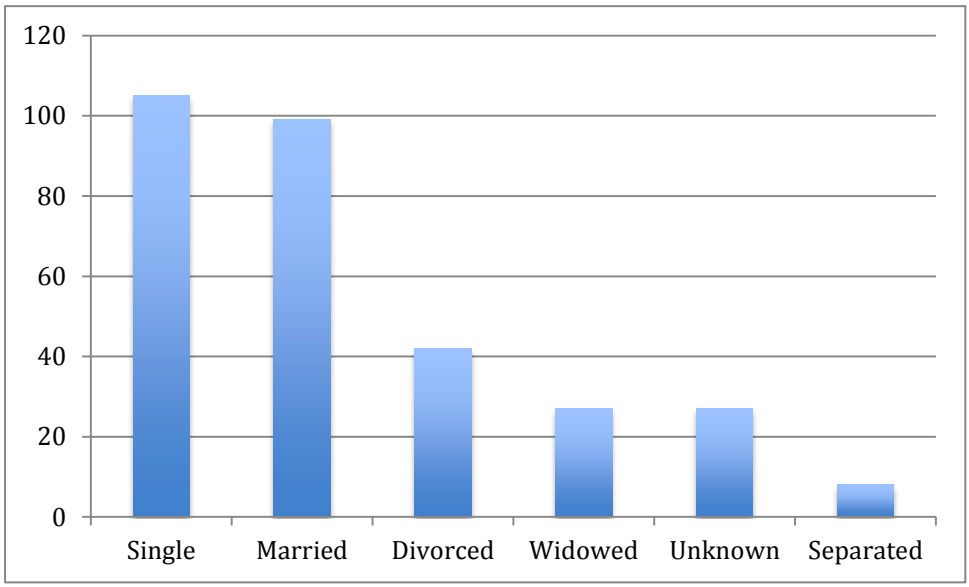
Figure 10.8: Number of Suicides in Herefordshire, 1994-2014, by age and sex



10.5.6. Marital Status

Figure 10.9 shows the number of suicides broken down by marital status. Approximately one third of people who committed suicide in Herefordshire during 1994-2014 were married and another third were single. The remainder were divorced, widowed or unknown. It is notable that the number of "single" individuals predominate, although this may be a coding issue, with divorced, and widowed individuals recorded as being single.

Figure 10.9: Number of Suicides by Marital Status



10.5.7. Means of Death

The data shows a striking disparity in means of death, when broken down by sex.. Whilst the most frequent means of suicide for the population was asphyxiation (56% of deaths in men and 43% of deaths in women), women were more likely to take poison or an overdose (49% of women compared to 23% of men). Men were more likely to shoot themselves (12% of men compared to no women) and use other 'violent' means of death (self-injury, traffic collision, burning, jumping/ falling from heights) women were more likely to commit suicide on railway tracks.

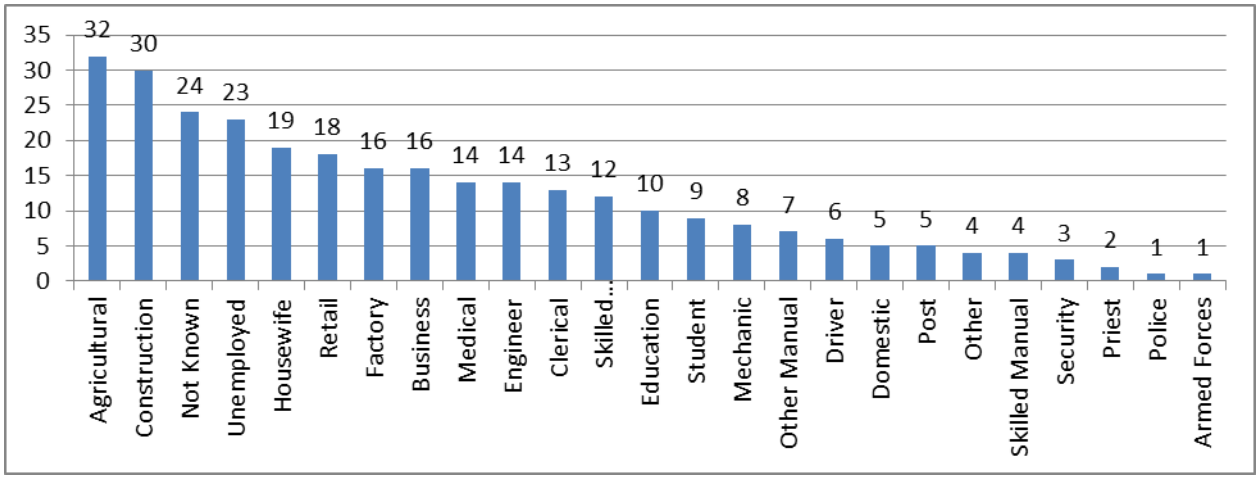
The most frequent form of asphyxiation was via hanging/ self-strangulation (81 men, 22 women), followed by drowning (9 men, 3 women), with three men killing themselves via plastic bag suffocation. There were 55 cases of asphyxiation where the means was unknown or unrecorded.

Means of poisoning was not sufficiently well recorded to enable breakdown by poisoning type.

People over 70 are recorded as using fewer means of suicide (either asphyxiation, self-poisoning or shooting). In the 70+ age band, 9 men (22.5%) committed suicide via self-shooting, compared to 9.4% of men aged 69 or younger. Men aged over 70 were therefore 2.4 times more likely to commit suicide via shooting than men aged under 70 (CI 1.1775 to 5.0706, p=0.165).

10.5.8. Occupation

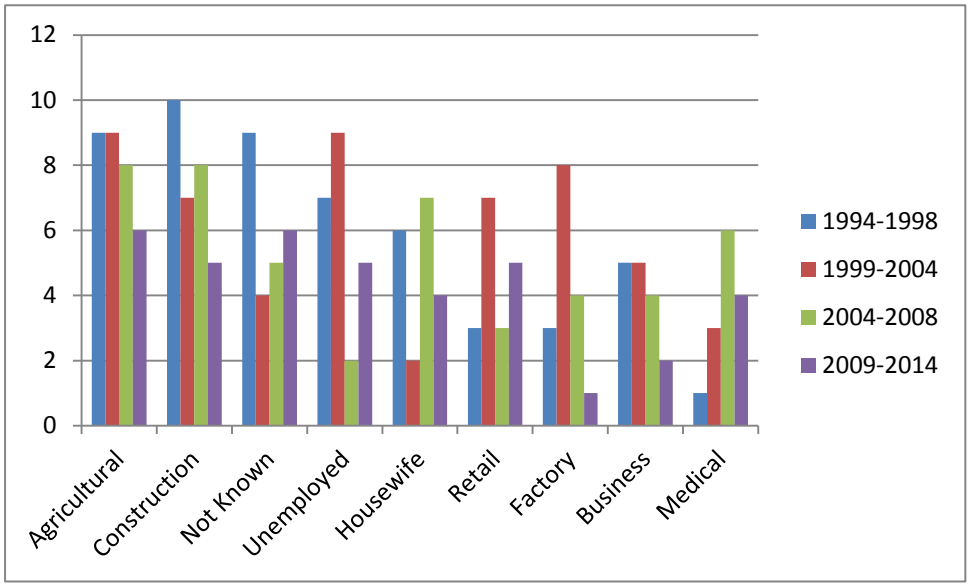
Figure 10.10: Frequency of Suicide by Occupational Group 1994-2004



Breaking down suicides by occupational grouping (Figure 10.10), it becomes clear that particular occupations predominate. Of known occupations, people employed in agriculture, construction, people who are unemployed, Housewives and people employed in retail have greatest frequency of suicide. In addition, 52 people (17.5% of those with recorded occupation) are recorded as being retired.

All persons recorded as “housewife” were female, whilst 17 of the 23 people recorded as “unemployed” were male, which may suggest that “housewife” may be a proxy for women not in paid employment. It was not possible to cross reference with Department of Work and Pensions data to identify if those recorded as housewives were in receipt of unemployment benefits.

Figure 10.11: Frequency of suicide by occupational group by five year bands



When suicide by occupational grouping are analysed by five year bands (Figure 10.11), notable variation becomes apparent. Whilst overall suicide rates have decreased over time, this is not borne out in all occupation groupings.

In 1994-1998, the highest numbers of suicide were identified for people employed in construction occupations, followed by agricultural workers and the unemployed. In the period 1999-2004, the unemployed and those employed in agricultural work had highest rates, with notable peaks in numbers of suicides by persons employed in factory and retail settings. In 2004-2008, construction and agricultural workers were most highly represented, with notable peaks amongst housewives and medical staff. For the most recent period, 2009-14, reflecting overall decreases in rates of suicide both locally and nationally, rates are highest in agricultural workers, construction workers the unemployed and retail workers. However, whilst rates had fallen in agricultural and construction workers relative to the previous five years, they had risen for the unemployed and those employed in retail.

It is difficult to draw any firm conclusion regarding trend by occupational group due to small numbers, although it may be suggested that there is a declining trend in suicides amongst people in agricultural occupations.

10.5.9. Contact with Services

Contact with services was poorly recorded in the coroner's records. A total of 46 people were recorded as having had recent contact with their GP, with 22 recorded as not having had recent contact and 232 (77%) not recorded or recorded as 'not known'.

Contact with mental health services is somewhat better recorded, with nearly one third (93 or 31%) of cases recorded as having received recent contact with a mental health team, half (149 or 49%) recorded as not having had contact and the remainder (58 or 19%) not recorded or recorded as 'not known'.

10.6. Discussion

The audit of suicide has highlighted a number of issues. On average, there are 15 suicides per year, ranging from 11 recorded suicides in 2003 to 22 in 2006. Changing patterns in rates of suicide do not conform to patterns seen nationally although there may be an element of lag, reflecting local changes in the economy and services within county. It is notable that for the period 2008-10 the rate locally (7.86/100,000 people) was below the national average (7.9/100,000 people) used as a benchmark within the national suicide prevention strategy.

Reflecting the national picture, men were nearly three times more likely to be recorded as having committed suicide than women. The highest number of suicides in men occurred in the age band 40-49 years (compared to 30-39 years in the national data), with the highest number of suicides in women occurring in the 70+ category (compared to 30-39 years nationally). Rates of suicide in the over 70s were markedly higher than seen nationally.

Suicide rates were highest in persons living alone (single, divorced, widowed) and so suggest that isolation is a factor in suicide locally.

Means of death showed a marked disparity in terms of sex, with men most likely to use asphyxiation (typically hanging) whilst women showed highest rates of poisoning or overdose. Men were far more likely to use "violent" means (Self shooting, self-injury, traffic collision, burning, jumping/ falling from heights), with men aged 70 and older being statistically more likely to shoot themselves than younger men in the county.

Agricultural and construction were the most represented occupational groupings for suicide in 1994-2014 although there were notable recording issues for persons recorded as unemployed, retired and "housewives".

Overall, contact with services was poorly recorded.

10.7. Recommendations

In addition to national and local recommendations contained within the national strategy, specific recommendations may be identified as a result of the intelligence contained in this audit:

10.8.1. Reduce the Risk of Suicide in Key High-risk Groups

The national strategy identified that those at the highest risk of suicide were:

- Young and middle-aged men;
- People in the care of mental health services, including inpatients;
- People with a history of self-harm;
- People in contact with the criminal justice system; and
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

Given the variety of groups highlighted both within the national strategy and within the audit, multi-agency partnership across multiple locations delivered by staff aware of and trained in reduction of suicide will be key to reducing risks of suicides in Herefordshire.

Specific recommendations that can be identified from this audit are to:

- Ensure that suicide prevention is included in the Joint Strategic Needs Assessments and the future Health and Wellbeing Strategy.
- Undertake a review of the medical records relating historical cases of suicide in the county to identify contact with medical services and ensure nationally recommended protocols and pathways are in place.

10.8.2. Tailor approaches to improve mental health in specific groups

As part of a whole population approach to improving mental health within Herefordshire (See chapter 4- “Feeling Good”) there is a need for interventions to support good mental health across the county. Specific groups have been identified particularly benefitting from targeted programmes. These include:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the Youth Justice System;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;

Given the intelligence contained in this audit, local measures should also be targeted at men, particularly those employed in agricultural, construction and low pay occupations; socially isolated individuals including unemployed and housewives, persons living alone and the elderly).

10.8.3. Reduce Access to the Means of Suicide

Suicide methods most amenable to intervention are:

- Hanging and strangulation in psychiatric inpatient and criminal justice settings;
- Self-poisoning;
- Those at high-risk locations; and
- Those on the rail and underground networks.

Given the information contained within this audit, it is recommended that the location of suicides are mapped, both historically and going forward, to identify opportunities for 'safe by design' interventions.

Given the significantly high risk of suicide by self-shooting in men aged over 70, there is a need for awareness amongst professionals, particularly GPs, of the potential for suicide by older men who own firearms.

There is a need to recognise the risk of suicide from prescribed medication for people with long term conditions.

10.8.4. Provide Better Information and Support to those Bereaved or affected by Suicide

Individuals and communities can be devastated by suicide, increasing the potential for increased risk in poor mental health and subsequent suicide events. As a result, it is vital to have in place effective local responses to the aftermath of a suicide and provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

In the context of Herefordshire, it is necessary to review suicides prospectively via Herefordshire Clinical Commissioning Group Mental Health Steering Group and ensure that effective protocols are in place to support family neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, and faith leaders to the incident.

10.8.5. Support the Media in delivering sensitive Approaches to Suicide and Suicidal Behaviour

Local services and agencies may wish to work with local and regional newspapers and other media outlets to encourage them to provide information about sources of support and helplines when reporting suicide and suicidal behaviour. Working with local media is particularly important where there is a specific location for suicide causing concern.

10.8.6. Support Research, Data Collection and Monitoring

To support research, data collection and monitoring we need to:

- build on the existing research evidence and other relevant sources of data on suicide and suicide prevention;
- expand and improve the systematic collection of and access to data on suicides; and
- monitor progress against the objectives of the national suicide prevention strategy.

In addition to the ongoing, prospective review of suicides outlined above, the Herefordshire CCG Mental Health Steering Group should support the Herefordshire Coroner's Office to improve recording of suicides via the use of available best practice proformas, in particular focussing on the recording of contact with services.

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