Suicide

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Introduction

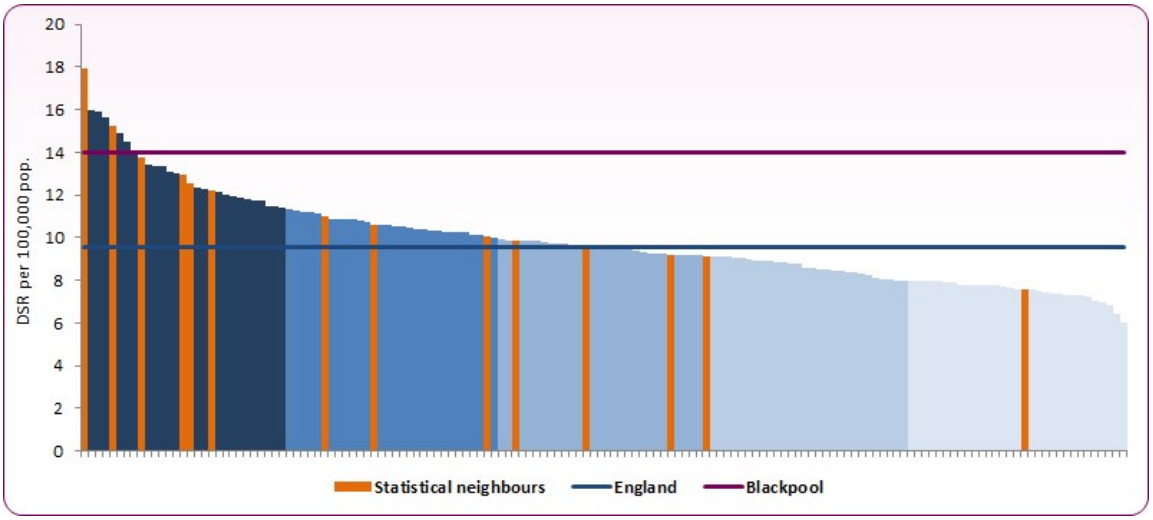
In March 2013, the Department of Health released a call to action to reduce the number of avoidable deaths in England. The call to action states for local authorities to lead the change to reducing preventable early death supported by both Public Health England (PHE) and the National Institute for Health and Care Excellence (NICE). Suicide remains a major public health issue as Blackpool continues to have one of the highest suicide rates in the country, particularly in males, and steps need to be taken to reduce the number of suicides locally.

Facts and Figures

Deaths from suicide in the UK decreased slightly from 5,965 deaths in 2016 (10.4 per 100,000 population) to 5,821 deaths in 2017 (10.1 per 100,000 population).[1]

- Blackpool has the ninth highest rate of suicide of any upper tier local authority in England, for all persons, during the period 2015-2017 (Figure 1).
- Blackpool has a significantly higher rate per 100,000 population (14.0 - 95% CI 10.4, 18.4) than England (9.6 - 95% CI 9.4, 9.7) as a whole[2].
- There were 51 deaths from suicide and undetermined injury in the 3 year period 2015-17.
- 78% (40) were male, 22% (11) female.

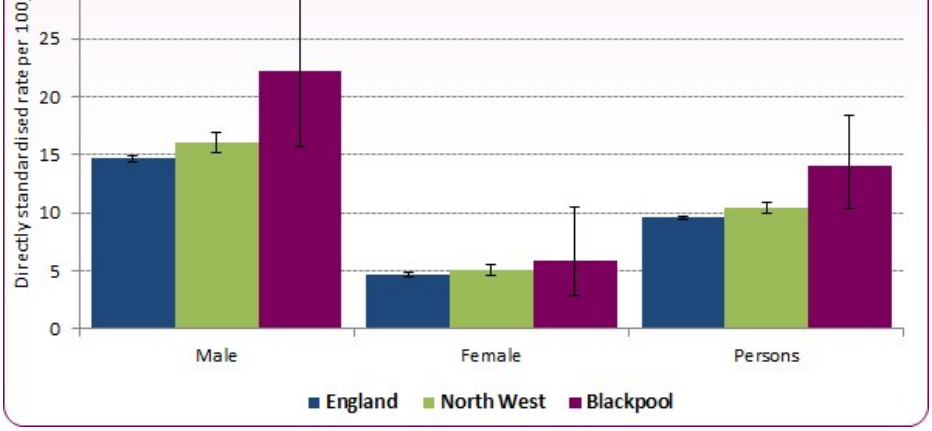
Figure 1: Mortality from suicide and injury undetermined, Upper Tier Local Authorities, 2015-17 (Persons aged over 10)



Source: PHE, Suicide Prevention Profiles

Figure 2 shows there is a significant difference in the number of suicides between the sexes in Blackpool, the North West and England, with mortality from suicide and undetermined injury at least 3 times higher in males.

Figure 2: Mortality from suicide and injury undetermined, males, females and persons, 2015-17

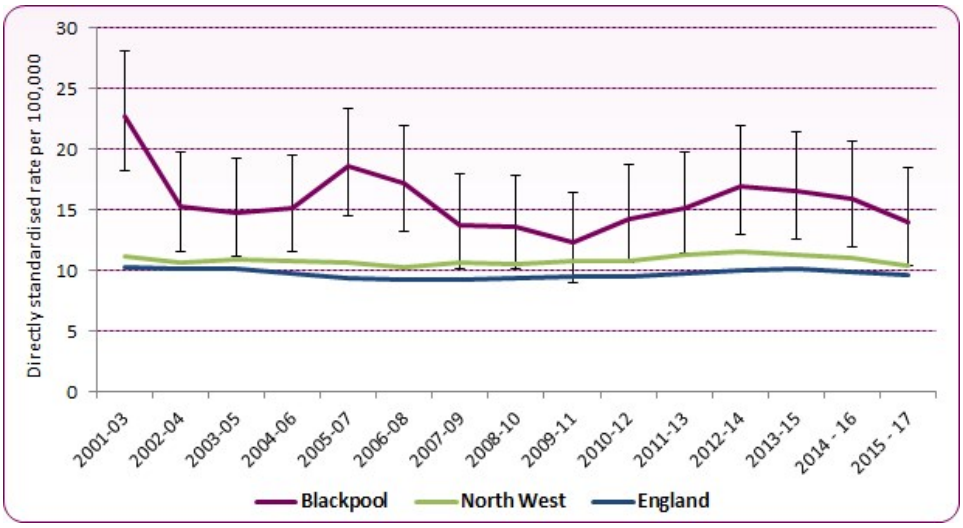


Source: PHE, Suicide Prevention Profiles

The most common age of suicide for males in Blackpool was between 25-45 years, with 15 deaths in this age group out of a total of 40 male deaths. 21 were aged over 45 and 4 were aged under 25. It's not possible to provide an age breakdown for females due to small numbers.

Figure 3 shows the trend in mortality rate from suicide in Blackpool has remained consistently significantly higher than England as a whole over the 13 year period.

Figure 3: Trend in mortality from suicide and injury undetermined, 2001-03 to 2015-17 (Persons aged over 10)



Source: PHE, Suicide Prevention Profiles

The most common method of suicide is hanging/strangulation which accounted for 59% of all suicides in Blackpool in 2015-17.

Blackpool Suicide Audit 2015 - Executive Summary

Public Health completed a suicide audit using data collected from the coroner's office, primary care records, secondary care records and custody. Due to relatively small numbers the audit is completed by pooling data over the three year period, 2011-13. Results from the audit found:-

- There were 55 deaths registered in 2011-13. For the purposes of the report only 50 deaths were audited due to a number of case files being unavailable.
- 74% (37) of deaths by suicide in 2011-13 were male, and the most common age recorded at time of death was 25-44 years.
- 26% (13) of deaths by suicide in 2011-2013 were female and the most common age recorded at time of deaths was 40-59 years
- Half of females (6/13) complete suicide in the month between December and January (6), the highest frequency of suicides in males occurred between May-July (21/31)
- Analysis of suicides by geo-demographic type (Mosaic) showed the highest number of suicides in categories L49 (disconnected youth), O63 (streetwise single), L52 (midlife stopgap), K46 (self-supporters) and L50 (renting a room).
- The most common method of suicide in males is hanging/strangulation with (52%)
- Over half (64%) of those who died by suicide did so at home.
- A history of depression, mental illness, history of drug and alcohol abuse, self-harm, having a long term condition and alcohol use present as high risk factors for suicide. Being unemployed, single, living alone, having financial and relationship difficulties also feature strongly as co-existing factors.

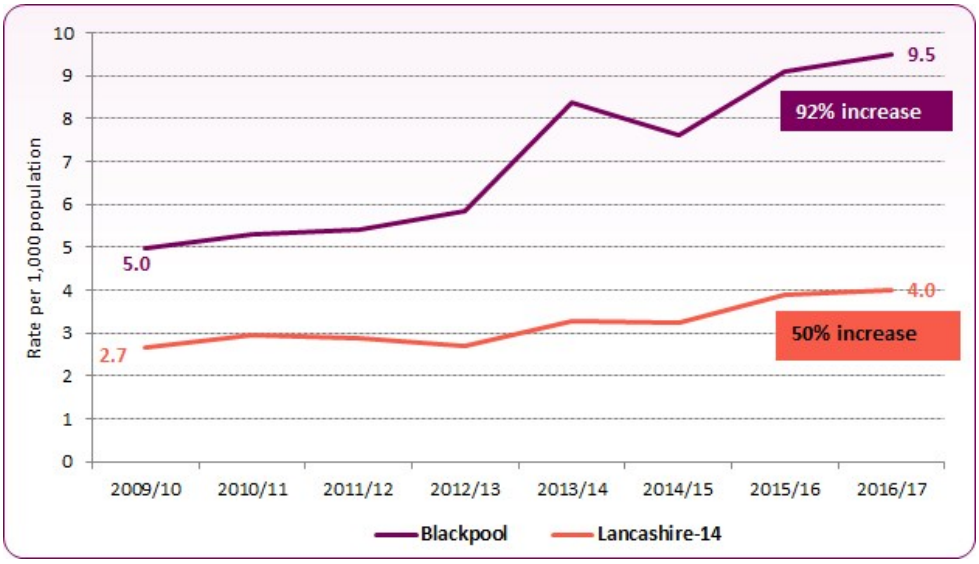
- Depression was the most common current and/or ongoing mental health diagnosis with 54% of females and 40% of males recorded as having depression in 2011-13.
- Nearly half of all suicides (46%) in contact with primary care beforehand had been prescribed medication by their GP.
- 22% (11) of completed suicides had a history of alcohol/drug misuse recorded in either the coroner's records or their primary care notes.
- Nearly half of all suicides (46%) had been in contact with primary care in the last month.
- 12% had contact with a health care professional (usually the GP) in the week before death, and 24% in the month before death
- 28% (14) of suicides had been in contact with specialist mental health services in their lifetime.
- 35% (13) of all male suicides and 38% of all women (5) were reported to have had either a lifetime history of self-harm or within the last 12 months of their lives.

Ambulance callouts relating to psychiatric problems and/or suicide

Data from Safer Lancashire[3] shows Blackpool has the highest ambulance incidence rate for psychiatric/suicide issues in the Lancashire-14 area. Although there were over 1,300 callouts for psychiatric/suicide issues in Blackpool in 2016/17 it is only a small proportion of the total requests received by the service; in 2015/16 there were over 32,000 callouts overall.

- Blackpool ambulance incidence rate for psychiatric/suicide issues is over twice the Lancashire-14 average of 3.9
- Incidents have increased 92% over the last 6 years from 5.0 per 1,000 in 2009/10 to 9.5 per 1,000 in 2016/17 (Figure 4)
- Incident rates for psychiatric/suicide issues range from 1.8 per 1,000 in Norbreck to 33.5 per 1,000 in Talbot
- Bloomfield, Claremont and Talbot have rates significantly higher than the Blackpool average and at least six time higher than the Lancashire-14 average
- In 2015/16 these three wards accounted for 46% (609) of the psychiatric/suicide issue ambulance incidents

Figure 4: Trend in ambulance incidence rates for psychiatric/suicide issues, Blackpool and Lancashire-14, 2009/10 to 2016/17



Source: Safer Lancashire MADE

Risk Factors

Suicide is a complex event, with rarely one significant contributing factor, and sometimes occurs for reasons that are not clear. Certain factors are known to be associated with increased risk. These factors include a history of depression, mental illness, history of drug and alcohol abuse, self-harm, having a long term condition and alcohol use. Being unemployed, single, living alone, having financial and relationship difficulties also feature strongly as co-existing factors.

The level of social fragmentation, with little in the way of social connections, has been strongly correlated with suicide rates.[4] During 2011-13, the suicide audit identified that 72% of males lived alone at the time of death. During the same period, 69% of women were reported to live alone, compared to 22% of women during 2007-09. If we also take into account the number who are divorced, widowed or separated, those who lose their lives to suicide due to the isolation of living alone is strongly significant.

More detailed analyse of suicides has profiled the cases in 2011-13 amongst Blackpool residents using the MOSAIC population segmentation tool. This showed the MOSIAC types with the largest number of suicides included L49: Disconnected Youth; Young people endeavouring to gain employment footholds while renting cheap flats, O63 Streetwise Singles; Hard-pressed singles in low cost social flats searching for opportunities and L52: Midlife Stop Gap; Maturing singles in employment who are renting short-term affordable homes.

National and local strategies

- Preventing Suicide in England: A cross-government outcomes strategy to save lives (The Department of Health, 2012) highlights a number of actions which local authorities and NHS providers can target their services. The actions include: Reduce the risk of suicide in key high-risk groups, Tailor approaches to improve mental health in specific groups, Reduce access to the 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 and Support research, data collection and monitoring.
- Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives (HM Government, January 2017) sets out what's being done to reduce deaths by suicide in England.
- PHE, Public Health matters - keeping our focus on suicide prevention (Jan 2017) is a resource to support local areas in their work to save lives
- Local suicide prevention planning - A practice resource is to support local authority public health teams to work with clinical commissioning groups (CCGs), health and wellbeing boards, the voluntary sector and wider networks of partners to develop or update local suicide prevention plans and embed work within local sustainability and transformation plans.

Recommendations

1) Ensure that all those working with high risk groups continue to have access to Applied Suicide Intervention Skills Training (ASIST) on suicide prevention, including those working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems.

- To ensure that staff of Housing Associations, Job Centres, and GPs that come into contact with individuals in distress as a result of benefit changes and other types of economic loss, know where to signpost individuals to appropriate support services and are ASIST trained.

2) Develop specific interventions for men aged 25 - 55 years to improve the mental health, resilience and access to support.

- When developing interventions these should be done in collaboration with the men they are designed for.
- Target campaigns and take services to where men are such as workplaces, online, pubs, sports grounds, betting shops, prisons etc.
- When commissioning suicide prevention activities particularly targeting adult men aged under the age of 50 years, attention needs to focused on 'out of hours' services and the workplace.
- Offer a range of support to individuals presenting in primary care including signposting for social support, such as housing, debt advice, bereavement and relationship difficulties, social prescribing and 'talking therapies'.
- Use mosaic profiles to target suicide prevention activities e.g. social marketing messages.

3) In light of the connection between drug and alcohol and mental health issues, an integrated approach to suicide prevention strategies for this cohort would provide more robust interventions.

- Local substance misuse agencies should ensure that all are competent to assess the risk and prevent suicide among individuals who are most vulnerable.
- Mental health and substance misuse workers to develop and facilitate joint working protocols
- Assertive outreach teams in both mental health and substance misuse services to prevent loss of contact with vulnerable and high risk patients
- Depression screening for elevated suicide risk for those admitted with alcohol/drug dependence in primary/secondary care

4) Review care pathways for people in contact with Accident & Emergency, Drug & Alcohol Services and NWAS who present with deliberate self-harm, with the aim to address the assessment of suicide risk, mental health needs and substance misuse.

5) Explore piloting "real-time" surveillance of suicides in collaboration with the police, who are usually first on the scene of suicide deaths. 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 improve access and provide timely support to people bereaved by suicide.

6) Pilot local GPs to provide Public Health with 'real time' significant event questionnaire.

7) Explore the development of a 'flag system' within Primary Care for frequent attenders to their GP.

8) Invest in and support campaigns to reduce loneliness and social isolation particularly targeting men who are in contact with drug and alcohol services.

9) Public health to review the process for future audits including the revision of the audit toolkit.

- Public health to develop more coherent links with coroner, custody, primary care and specialist mental services to

improve future audits and overcome difficulties with incomplete information.

10) Work with Blackpool Council & CCG marketing & communications team to encourage local media to report stories around suicide and self-harm responsibly and to provide information about sources of support and helplines when reporting suicide and suicidal behaviour.

11) Work with planning departments and developers to include suicide in health and safety considerations when designing structures which may offer suicide opportunities. Also work with Neighbourhood services to designing and maintaining suicide prevention signage, particularly at hot spots.

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[1]Suicides in the UK: 2017 registrations

[2] Public Health England, Suicide Prevention Profile

[3] Safer Lancashire MADE: MMIR and District Profile 15.1 http://www.saferlancashire.co.uk/2011/

[4] Middleton N, Whitley E, Frankel S, Dorling D, Sterne J, Gunnell D. Suicide risk in small areas in England and Wales, 1991-1993. Soc Psychiatry Epidemiol 2004; 39:45-52.

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