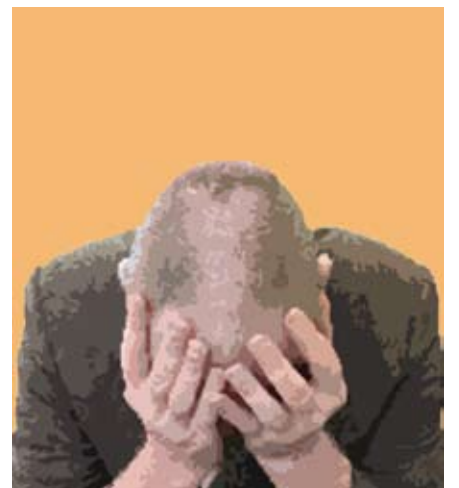
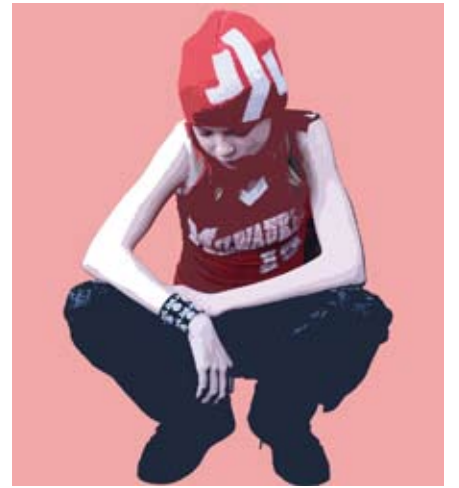




## Gloucestershire Suicide Audit

2005





# Gloucestershire Suicide Audit 2005

---

## 1. Introduction:

- 1.1 On average someone attempts suicide in England every two hours, with 5755 deaths in 2003. There has been an encouraging and sustained fall in the rate of suicide amongst young men under the age of 35. However the death rate amongst this group is still high in comparison with the general population. (NIMHE 2005). It is also the main cause of premature death in people with a mental illness. Suicide is a devastating event. The factors associated with it are complex and varied and the consequences in emotional and practical terms are wide ranging.
- 1.2 There are many different reasons why someone decides to take their own life and each suicide represents both an individual tragedy and a loss to society. For this reason the government decided to make suicide prevention a health priority. Saving Lives Our Healthier Nation set a target of a 20% reduction in suicide deaths by 2010.

## 2. National context:

- 2.1 The National Service Framework (NSF) for Mental Health implemented in 1999 was an important milestone, addressing the mental health needs of working age adults up to the age of 65. It defined service models for promoting mental health and treating mental illnesses and set national standards against which local progress could be assessed. The NSF provided the framework for the delivery of safe, efficient and effective modern mental health services, to promote good mental health within the whole population.
- 2.2 A National Suicide Prevention Strategy for England was produced in September 2002, which aimed to reduce the number of suicides by modifying risk factors and strengthening crisis support systems as identified in Standard Seven of the NSF for mental health.
- 2.3 The Annual Report on progress towards the National Strategy by NIMHE in 2005 demonstrated that whilst suicide rates fluctuate year on year there has been a downward trend since the early 1980's. The national data up to 2003 showed a 6% reduction from the baseline. If this trend continues through to 2010 the target nationally will be met.
- 2.4 It is difficult to make an accurate representation of statistics regarding Black and ethnic minority groups, which is not surprising as there are at least 250 different groups so how can there be one representation. Patterns and themes are due more to social and economic factors rather than culture or race. (Sewell 2006). Local data regarding black and ethnic groups and suicide is not collected.
- 2.5 Following the National Strategy and due to concerns of the Gloucestershire Healthy Living Partnership and the Gloucestershire Health Community "Preventing suicides in Gloucestershire – a strategy for action" has been developed.
- 2.6 There is increasing evidence nationally that people struggling with issues of sexuality and gender identity face increased likelihood of attempting suicide. (Roen & Scourfield). No statistics are collected locally regarding sexuality and rates of suicide.

## 3. Local Context:

- 3.1 On average there are between 50-60 deaths from suicide and injury undetermined each year in Gloucestershire. The mortality rates are similar to the national average rate and the average of the South West. However rates vary considerably and are subject to annual fluctuations. In recent years Cheltenham has had a consistently higher death rate from suicide and undetermined injury than the rest of the county and slightly higher than the national average (in view of the small numbers which may lead to wide variations these numbers need to be considered with caution.)
- 3.2 Gloucestershire's trend of age standardised death rates from suicide and undetermined injury showed an increase from 8.13 deaths per 100,000 people between 1995 and 1997 to 9.39 from 1999 and 2001 and 8.7 for between 2002-2004.



## 4. Suicides and Mental Health:

### 4.1 National picture:

In figures published by the ONS in 2002 over two thirds of the sample of people with a diagnosis of a psychotic illness had thought about suicide at some time in their lives and 45% had attempted suicide. In addition 21% had harmed themselves without intending to commit suicide. Suicide rates reflect the mental health of the community as a whole, Gloucestershire and Nationally there has not been limited investment in community mental health services. In Gloucestershire any new investment has been on private placements, which cost a huge amount of money concentrating on a small number of people. By investing here it is has not been possible to invest in Community Services, funding should be put towards suicide prevention and mental well-being, investing in community Mental Health Services and building on this. Mental Health Service users are a high-risk group for suicide. Research nationally shows that 'Around 40% of patient's suicides happen during or soon after in-patient care and the prevention of these deaths should be made a priority. (Appleby, L 2001). The latest data from NIMHE show that the numbers of inpatient suicides have dropped from 215 in 1997 to 156 in 2002.

### 4.2 Local picture:

The table below shows that deaths from suicide and undetermined injury in 2004 43% had an inpatient episode in the 12 months previous however only 16% were to a mental health speciality, 18% with a mental health diagnosis and only 12.5% with a history of self-harm in the preceding 12 months. This difference in figures holds true for the outpatient and A& E attendances also. Also included is the number of deaths from suicide and injury undetermined where there had been no contact with hospital services in the preceding 12 months. These make up 27% of the numbers.



#### 4.3 According to the Annual Report of the Director of Public Health (Gloucestershire) 2000

- 90% of suicides have some form of mental disorder
- 66% have had contact with their GP in the last month
- 33% have expressed clear suicidal intent
- 25% are psychiatric outpatients

Deaths from suicide and undetermined injury in Gloucestershire occurring in 2004.

	Number	%
No of deaths	56	-
Number with NHS number recorded	56	100
<b>Inpatients</b>		
Deaths with an NHS number link to an inpatient episode in the preceding 12 months	24	43
Deaths with an NHS number link to an inpatient episode in a mental health speciality in the preceding 12 months	9	16
Deaths with an NHS number link to an inpatient episode with a mental health primary diagnosis in the preceding 12 months	10	18
Deaths with an NHS number link to an inpatient episode with a mental health primary diagnosis suggesting self harm in the preceding 12 months	7	12.5
<b>Outpatients</b>		
Deaths with an NHS number link to an outpatient appointment in the preceding 12 months	27	48
Deaths with an NHS number link to an outpatient attendance in the preceding 12 months	25	45
Deaths with an NHS number link to an outpatient appointment in a mental health speciality in the preceding 12 months	15	27
Deaths with an NHS number link to an outpatient attendance in a mental health speciality in the preceding 12 months	14	25
<b>A&amp;E attendances</b>		
Deaths with an NHS number link to an A&E attendance in the preceding 12 months	24	43
Deaths with an NHS number link to an A&E attendance with a mental health primary diagnosis in the preceding 12 months	<5	<10
Deaths with an NHS number link to an A&E attendance for self harm in the preceding 12 months	7	13
<b>Community Mental Health data</b>		
Deaths with an NHS number link to community caseload in preceding 12 months	20	36
<b>No contact with services</b>		
Deaths with an NHS number with no contact with the above services in preceding 12 months	15	27

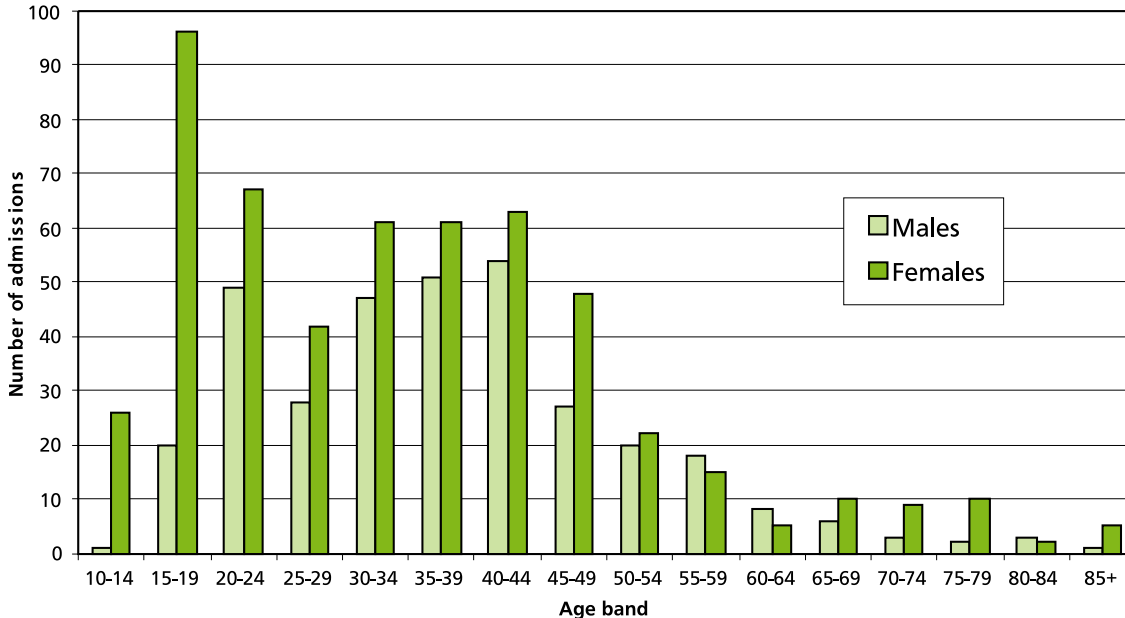
Source ONS



## 5. Deliberate Self Harm

5.1 Deliberate Self Harm (DSH) includes methods such as overdose, electrocution and wounding although the most commonly used is self-poisoning, by both men and women. This picture is reflected in Gloucestershire (2004) showing drug overdose was by far the most common method across the County to be recorded. These were concentrated around the deprived central wards in the county. DSH is strongly associated with the manual occupational social groups, the unemployed and socio-economic deprivation. In 2003 there were 762 hospital admissions for deliberate self-harm. In 2004 this number had risen to just under 900.

Emergency admissions for self harm (all types) 2004 by age and gender



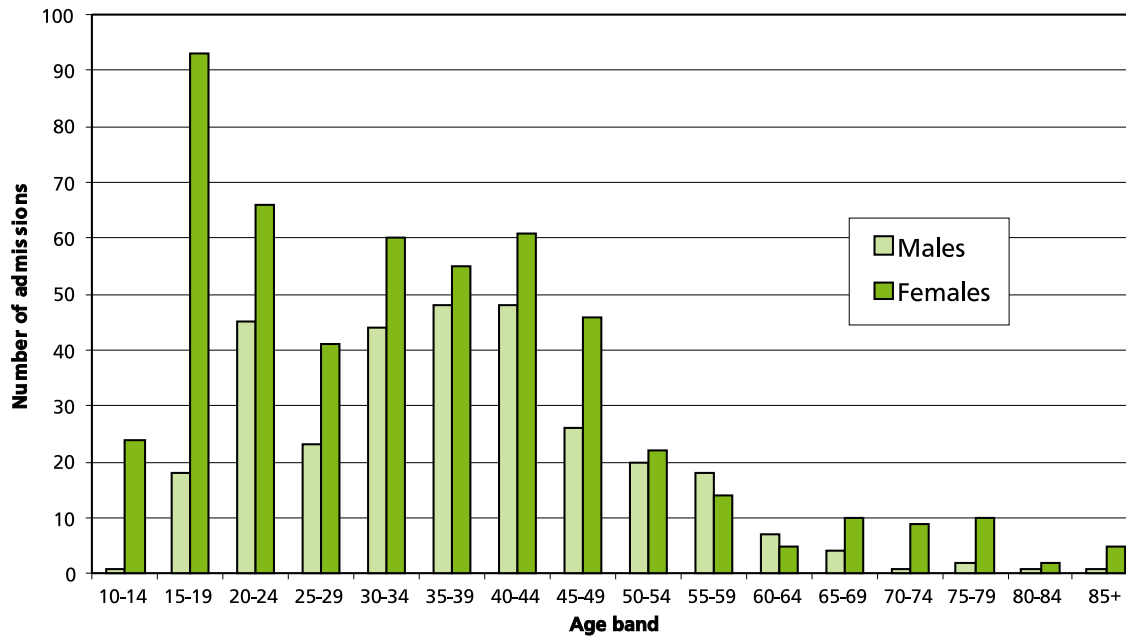
Source Gloucestershire public health Intelligence Unit 2005.

- 5.2 Whilst 15-19 year old age bands feature the highest rate of admission following self-harm the rates remain high and through the years up to 49 for women with some fluctuation. Deliberate self-harm is for many used as a way of coping with life and most commonly starts in teenage years. Some people will at this stage self harm and find it does not help them so will not repeat the process.
- 5.3 According to Hawton 2002 of 398 15-16 year olds who reported self-harm in the previous year only 12.6% were seen by medical services.
- 5.4 There is a link between self-harm and completed suicide that is reported by the Samaritans (1998) one out of every 100 attempts will result in death within one year.
- 5.5 For many people who use self-harm, as a way of coping there is no suicidal intention, however some will die as a result of that action.



5.6 Some individuals who attempted suicide but did not die will go on to self-harm as a means of coping.

Emergency admissions for self harm (self-poisoning) 2004 by age and gender



Source – Gloucestershire public health intelligence unit 2005

5.7 Each admission requires drilling down in order to determine circumstances and what may have influenced decisions and choices.

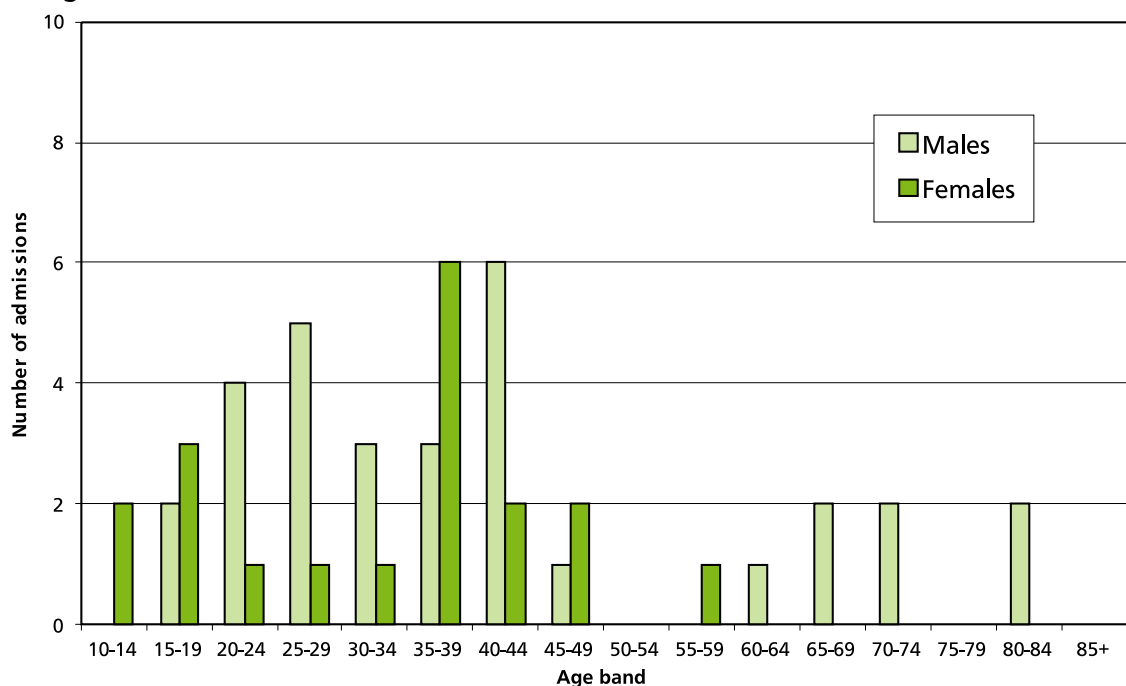
5.8 This is a complex and emotive area but in purely financial terms warrants further investigation in order that resources can be successfully be used in prevention.

5.9 If admissions could be reduced the money saved could be used to focus on Community Mental Health Services or be tied into school health services.

5.10 The majority of the admissions are females following self-poisonings with drugs.

5.11 The Samaritans (1998) state that the more a person self-harms the greater the risk that they will eventually kill themselves.

Emergency admissions for self harm (other methods excluding self-poisoning) 2004 by age and gender



Source – Gloucestershire Public Health Intelligence Unit 2005 (Please note different perpendicular axis to this graph)

5.12 The above graph demonstrates that when self-poisonings are taken out from the causes of admission for self-harm the rates for men become more dominant. However the numbers here are very small as most admissions are following poisoning.

5.13 The following table illustrates the other methods of self-harm that resulted in admission to acute hospitals.

Means of deliberate self harm	Numbers
Intentional self poisoning by drugs	805
Intentional self poisoning by exposure to alcohol	7
Intentional self poisoning by exposure to gas or vapours	<5
Intentional self poisoning by pesticides	<5
Hanging or strangulation	7
Drowning or submersion	<5
Smoke, fire or flames	<5
Sharp objects	29
Jumping from a high place	<5
Crashing of motor vehicle	<5
Other specified	<5
Other not specified	<5

Source – Gloucestershire Public Health Intelligence Unit 2005

## 6. Suicides and Age:

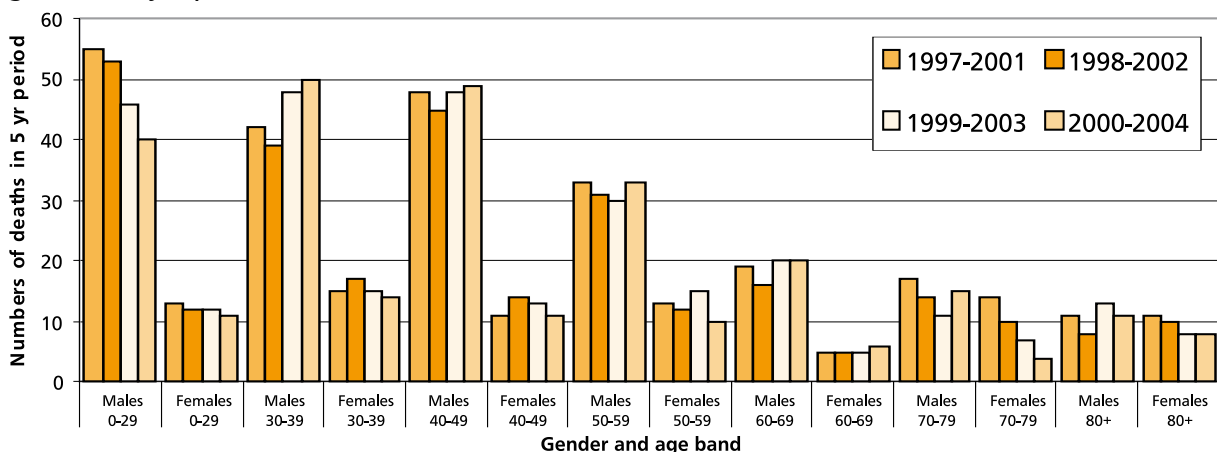
### 6.1 National Picture:

The majority of suicides nationally continue to occur in adult males under the age of 40. In the last thirty years of the 20<sup>th</sup> century suicide rates had fallen in older men and women but risen in young men. We are now seeing evidence of a sustained fall in suicide among young men although the rate remains high in comparison to the general population. (NIMHE 2005)

### 6.2 Local Picture:

Up to 1990, in Gloucestershire it was the older age groups who were at the highest risk. In females, with the exception of 15-24 year olds, there had been a marked decline in suicide rates, especially for the over 45 years. However the figures for 2004 appear to be changing again. When figures are broken down to produce a yearly suicide undetermined death rate the numbers are small and very volatile this means that small changes in number will result in a large variability in the rate.

Mortality from suicide and injury undetermined in Gloucestershire: numbers of deaths by age band & gender - 5 yrs pooled



Source ONS

- 6.3 In the UK 16 children (aged under 18 years) kill themselves each year as a result of being bullied at school. The figure for bullying or harassment for adults is not recorded, but it is thought to be a significant proportion of the 5-6000 suicides per year. Bullying, harassment and abuse causes injury to health, which is often diagnosed as stress and anxiety but may include depression.
- 6.4 Young people who have been physically or sexually abused are often at increased risk of suicide or deliberate self-harm. Family break-up and relationship problems are all causes of increasing stress and anxiety for young people.
- 6.5 The increase in young male suicide in England and Wales in the last 30 years has paralleled rises in a number of risk factors for suicide in this age group, namely unemployment, divorce, alcohol and drug misuse.

- 6.6 Drug misuse is thought to be a significant factor in suicide in the young. Both alcohol and drugs can affect thinking and reasoning ability and can act as a depressant. They decrease inhibitions, increasing the likelihood of a depressed young person making a suicide attempt.
- 6.7 Suicide rates nationally in older people of both sexes have dropped since the 1950's. The suicide rates in men are still higher than those in women. Suicide in older people is associated with depression, physical pain such as chronic back pain, living alone and feeling of hopelessness and guilt (The Samaritans, 1998).
- 6.8 A study of suicide in the over 65's age group showed that in approx one third of cases, alcohol had been used to "facilitate" the suicide and 10% of those who killed themselves were addicted to alcohol.
- 6.9 Research has shown that the majority of people who commit suicide die because they are inadequately supported and or have poor medical care. Studies show that declining suicide rates in older people may be due to increased levels of income support and welfare provision. Most suicides in older people occur in the community, and most have no contact with old age psychiatry services.

## 7. Suicide and occupation:

### 7.1 National Picture:

The analyses by occupation and method suggest that there is a link between suicide rates and access to, and knowledge of, effective means of committing suicide.

7.2 Research shows those who are unemployed are three times more likely to commit suicide than those in employment. It is higher among unskilled men, who are four times more likely to commit suicide than those in professional work.

7.3 The National Suicide Prevention strategy lists certain occupational groups as having a higher risk of suicide; this includes medical related professions and agricultural workers.

### 7.4 Local Picture:

In 2004 there were no deaths from suicide within the medical related professions. Despite Gloucestershire being a rural county the deaths related to agricultural occupations are also lower than anticipated. As the table below shows we seem to show an overrepresentation of occupation not listed and retired people that die by suicide. Rather than the nationally accepted high-risk occupations. As the numbers are small and liable to fluctuations it is important to be wary in making too much of these numbers.

**Deaths from suicide and injury undetermined by occupation of deceased in Gloucestershire 2004.**

Occupation	Persons
Not stated	9
Retired	11
Doctor/Nurse	0
Agriculturally related	<5
Other Stated	31

ONS 2004

- 7.5 The above table shows that of the 47 people for whom an occupation was listed at the time of death 11 appear to be retired. For 9 individuals the occupation was not listed.
- 7.6 Unemployment rates for Gloucestershire are below the average for England and Wales, however, there is a clear relationship between health and employment. Some ill-health may lead to unemployment, but unemployment, both directly and indirectly through it's consequences of reduced income and social networks, appear to have a causative role on ill health, particularly mental health and well-being. Both suicide and mental illness are associated with deprivation but suicide is more strongly associated with social fragmentation, characterised by neighbourhoods with high levels of private renting, single person households, unmarried persons and mobility.

## 8. Methods of Suicide:

- 8.1 Nationally hanging and suffocation is now by far the most common method of suicide for men, accounting for nearly half all male suicide deaths. The relative importance of drug related or other poisoning (including motor gas poisoning) has decreased accordingly. Among women, drug related poisoning is still the most common method of suicide. This is reflected in Gloucestershire with hanging being the commonest method in 2002/3&4.
- 8.2 Self-poisoning is a more common method of suicide used by men and women in health care professions than in the population as a whole, partly due to the fact they may have more ready access to prescription drugs. There were no deaths due to suicide listed from these occupations in Gloucestershire in 2004.

Causes of death	Persons
Hanging and strangulation	29
Toxic effect of drug overdose	8
Firearm	<5
All other methods	15

Source ONS

## 9. Conclusion

In the 2000 annual report of the Gloucestershire Director of Public Health a section on preventing suicide was included. This document highlighted certain issues.

- Suicide rates in Gloucestershire, (which were higher than national rates), have reduced over the past decade. This reduction is primarily due to reduced death rates in men. Rates in females have stayed fairly constant.
- Rates amongst older people are substantially higher than national rates, although the numbers are very small, and the data does not allow specific conclusions to be drawn. It does suggest, however, that exploration of the diagnosis and management of depression in older people might be valuable.
- Self-harm is far more common than suicide but both are strongly related to social deprivation. Deliberate self-harm is a significant risk factor amongst people who commit suicide.
- Three quarters of suicide are not in contact with the mental health services, although most have some significant mental health disorder.
- Amongst people in contact with mental health services, a national review found that in most cases the local mental health teams felt there was more that could have been done to reduce risk.
- Prisoners are a particularly high-risk group.
- Local audits are a good way of identifying any local issues that need addressing.

In the following four years there have been fluctuations in the rates of suicide that took Gloucestershire above the national rate.

Gloucestershire has continued to show rates that are higher in the older age groups.

Self-harm continues to be a far greater problem in terms of numbers involved. The numbers have risen and continue to be linked to areas of social deprivation.

There continues to be a proportion of suicides where there has been no contact with specialist services.



## 10.Recommendations

- 10.1 This audit should be repeated on an annual basis.
- 10.2 This audit should link in to the suicide prevention strategy.
- 10.3 Care needs to be taken over the statistics when small numbers are involved and therefore liable to fluctuation.
- 10.4 Good work that has already been done for example with young men should continue.
- 10.5 Attention and focus should be given to the management of people who deliberately self harm.
- 10.6 Reducing the rates of suicide and deliberate self-harm will require the involvement and contributions of many different stakeholders.



