Suicide Prevention Programme

Learning Set 14

20 February 2024

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

UCL

NCISH

IMPROVING MENTAL HEALTH SAFETY
National Suicide Prevention

NCCMH

Welcome

Tom Ayers

Director

National Collaborating Centre for Mental Health (NCCMH)

X / Twitter

- We will be live tweeting this event so you may see the QI coaches on their phones throughout the day. Please follow us **@NCCMentalHealth**.
- We encourage use of X/Twitter and social media to share the work that you are doing throughout the collaborative.
- However, we kindly ask you not to tweet people's names, photographs of people's faces or their talks without their permission.

Thank you!!

NCCMH

Agenda

Time	Item	Speaker(s)
09:30 – 10:00	**Registration and refreshments**	
10:00 – 10:10	**Welcome**	Tom Ayers Director, NCCMH
10:10 – 10:25	**Energiser**	All
10:25 – 11:10	**Quality improvement for suicide and self harm prevention: the story so far**	Professor Nav Kapur, NCISH
11:10 – 11:20	**Break**	
11:20 – 12:35	**Sharing good practice in suicide prevention and learning from the Suicide Prevention Programme**	NCCMH
12:35 – 13:20	**Lunch**	
13:20 – 14:00	**The new suicide prevention strategy and the future**	Professor Louis Appleby, NCISH
14:00 - 14:50	**Panel discussion:** • **Nav Kapur**, Professor of Psychiatry & Population Health • **Louis Appleby**, Professor of Psychiatry • **Sue Willgoss,** Advisor for Suicide Prevention with Lived Experience • **Adele Owen**, Greater Manchester Suicide Prevention & Bereavement Support Programme Manager	Chair: Tom Ayers
14:50 – 15:00	**Close**	Tom Ayers

NCCMH

Quality Improvement for suicide and self-harm prevention: the story so far

Professor Nav Kapur

Head of Suicide Research, Professor of Psychiatry and Population Health

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

NCISH

IMPROVING MENTAL HEALTH SAFETY
National Suicide Prevention

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

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MANCHESTER 1824
The University of Manchester

The Manchester Self-Harm Project

NCISH

NIHR | Greater Manchester Patient Safety Translational Research Centre

HQIP
Healthcare Quality Improvement Partnership

Quality improvement for suicide and self harm prevention: the story so far

Suicide Prevention QI Programme
Royal College of Psychiatrists February 2024

Professor Nav Kapur

the centre for suicide prevention

the national confidential inquiry into suicide and homicide by people with mental illness

Quality Improvement for Suicide Prevention: the evidence

Professor Louis Appleby
Professor Nav Kapur

The National Confidential Inquiry into Suicide and Safety in Mental Health

30 April 2018

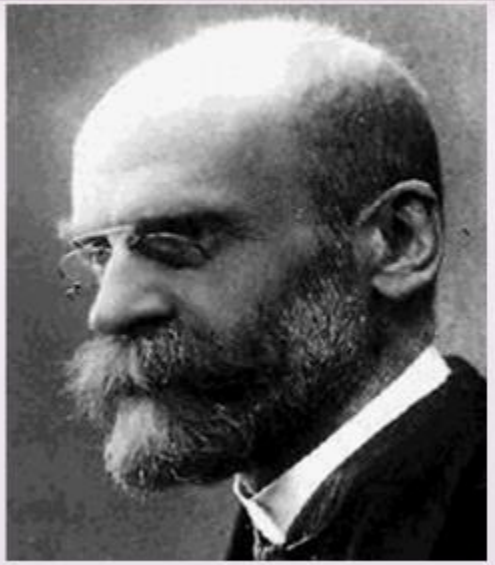
HQIP
Healthcare Quality Improvement Partnership

MANCHESTER 1824

HQIP

MANCHESTER 1824

Emile Durkheim 1858-1917




172002

Outline

- QI for suicide prevention
- Improving community based services for self-harm
- CQUIN indicator for self-harm

Outline

- **QI for suicide prevention**
- Improving community based services for self-harm
- CQUIN indicator for self-harm

Approach

8x **priority high rate STPs** 18/19 funding plans *(drawn from multi-agency plans **rec 3)***

£ focus: MH service quality, self-harm, middle aged men, primary care access,

Public Health Suicide Community-Based Prevention Interventions

Improving quality of mental health services & patient safety ***(rec 57)***

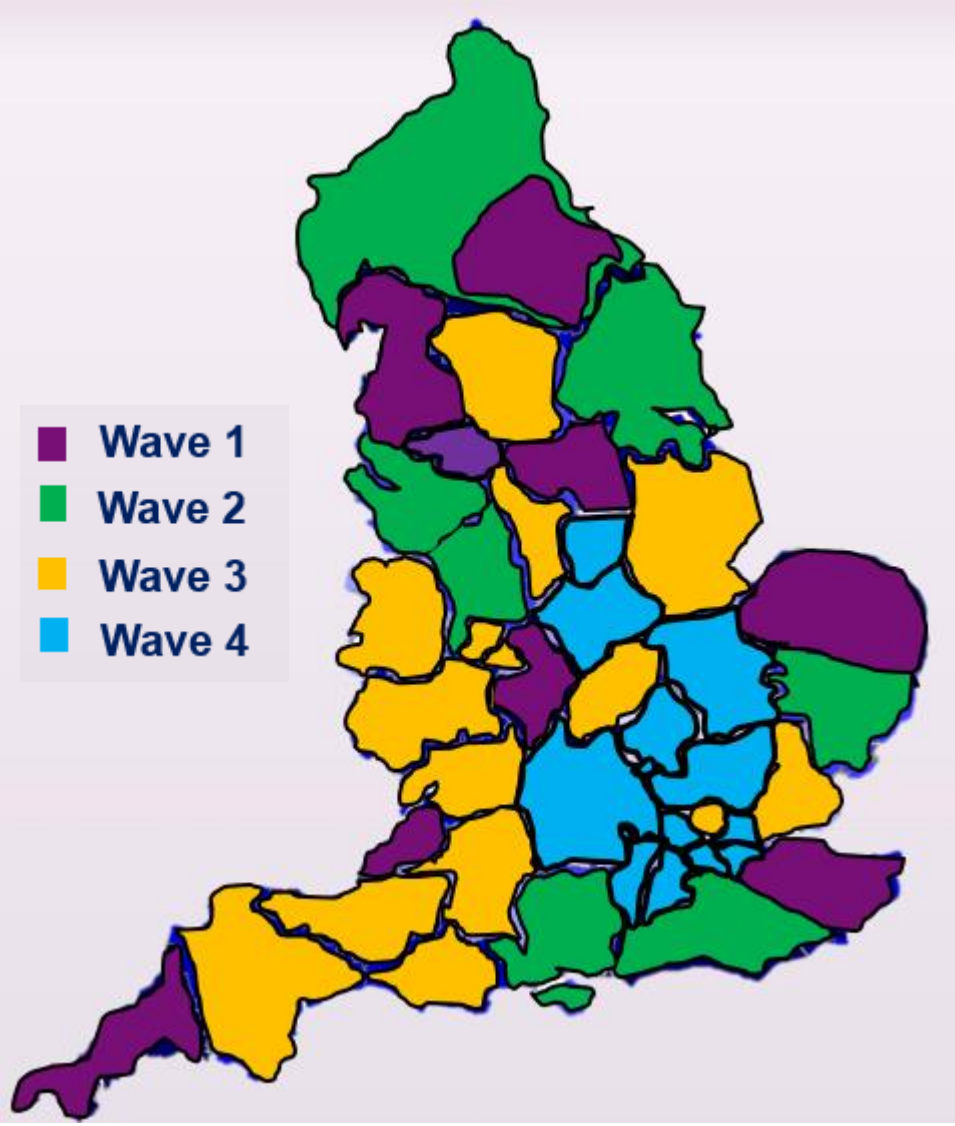
Incl. MH inpatients

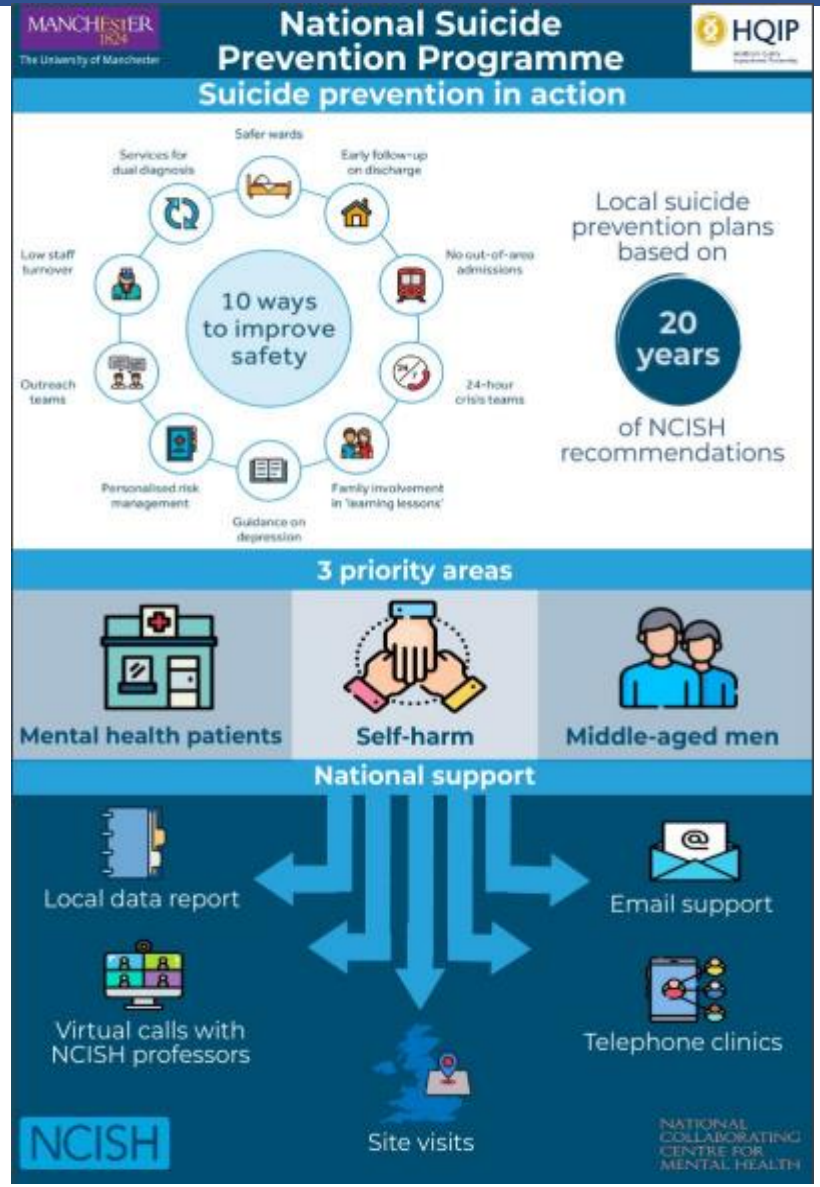
Zero Suicide Ambition

Embedded in core STP MH programme

Delivery support: National Quality Improvement Programme (18/19 priority STPs) & Regional Implementation Support Offer (all STPs)

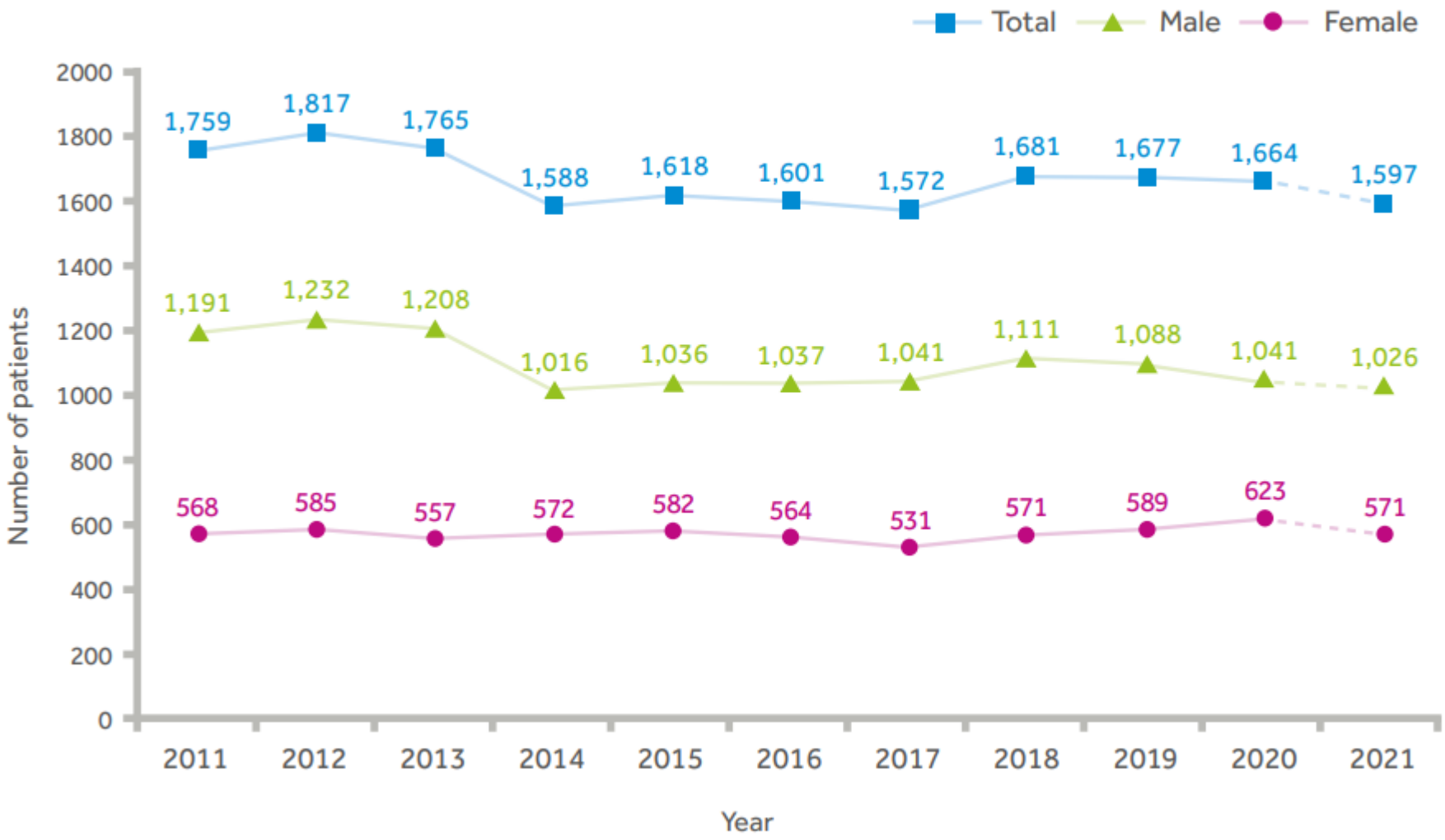
Programme overview





Patient suicide

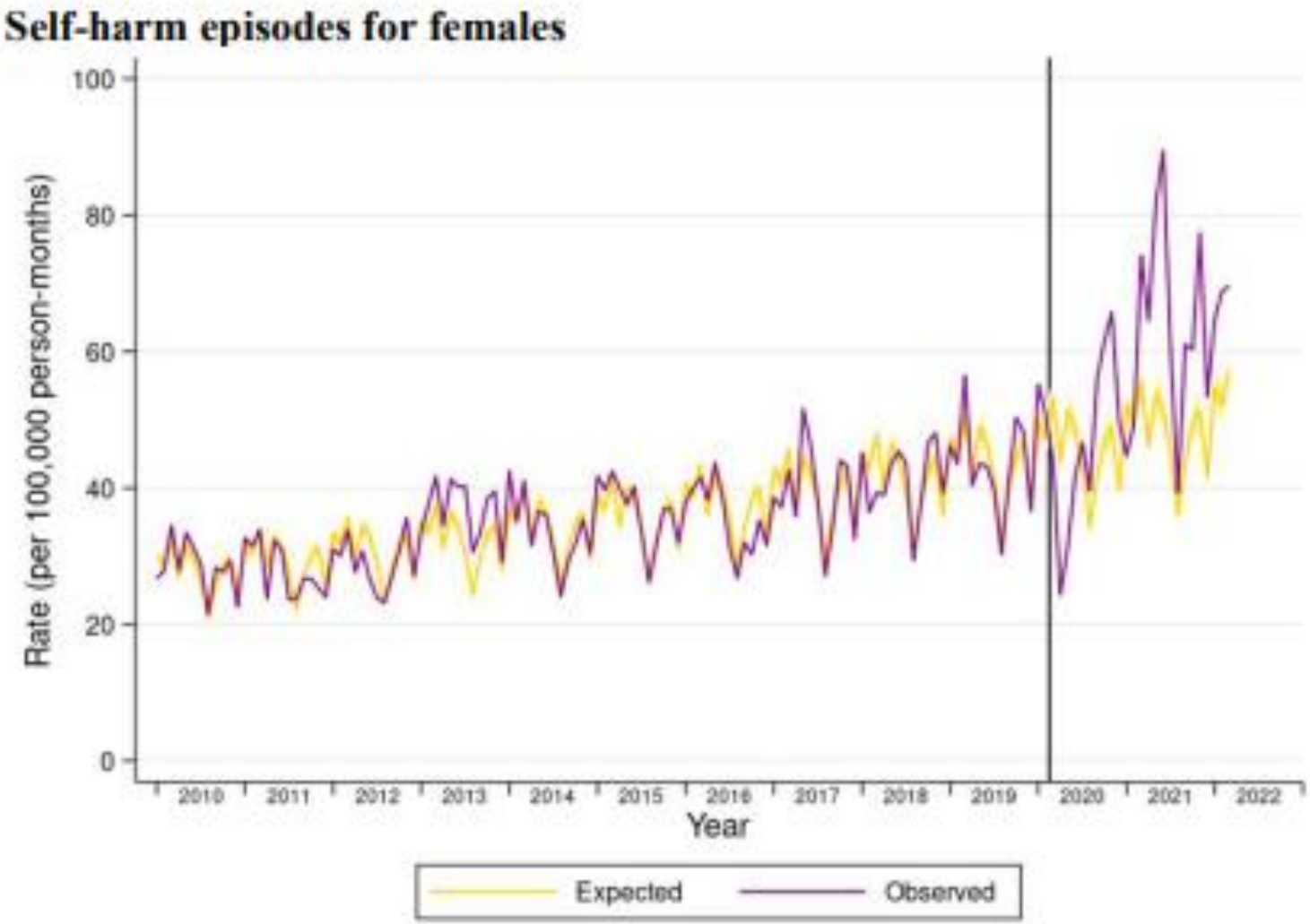
Figure 6: Patient suicide: numbers by sex in the UK



‘10 ways’ to improve safety

Source: NCISH

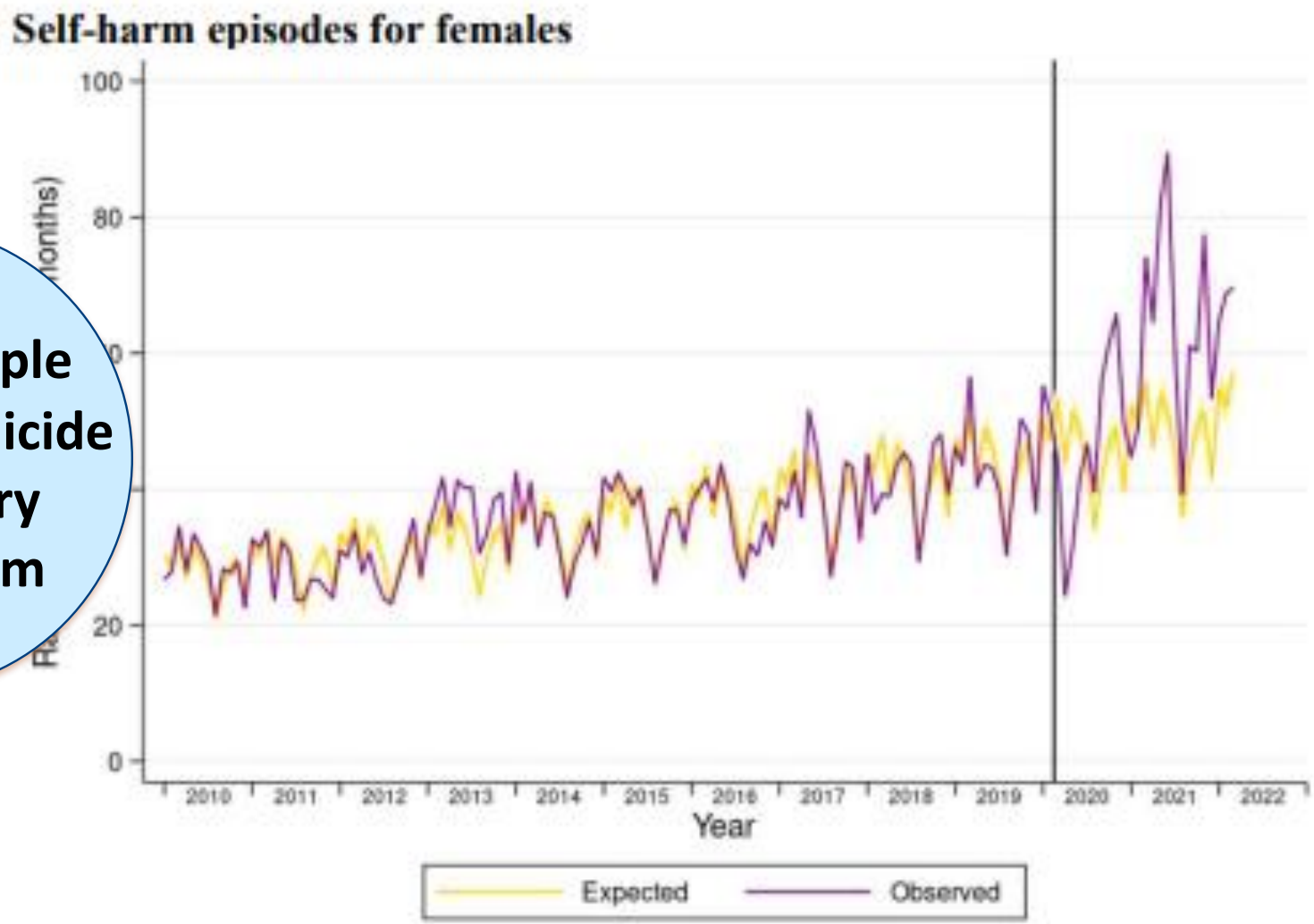
Self-harm



The Lancet Child & Adolescent Health DOI: (10.1016/S2352-4642(23)00126-8)

Self-harm

50% of people who die by suicide have history of self-harm



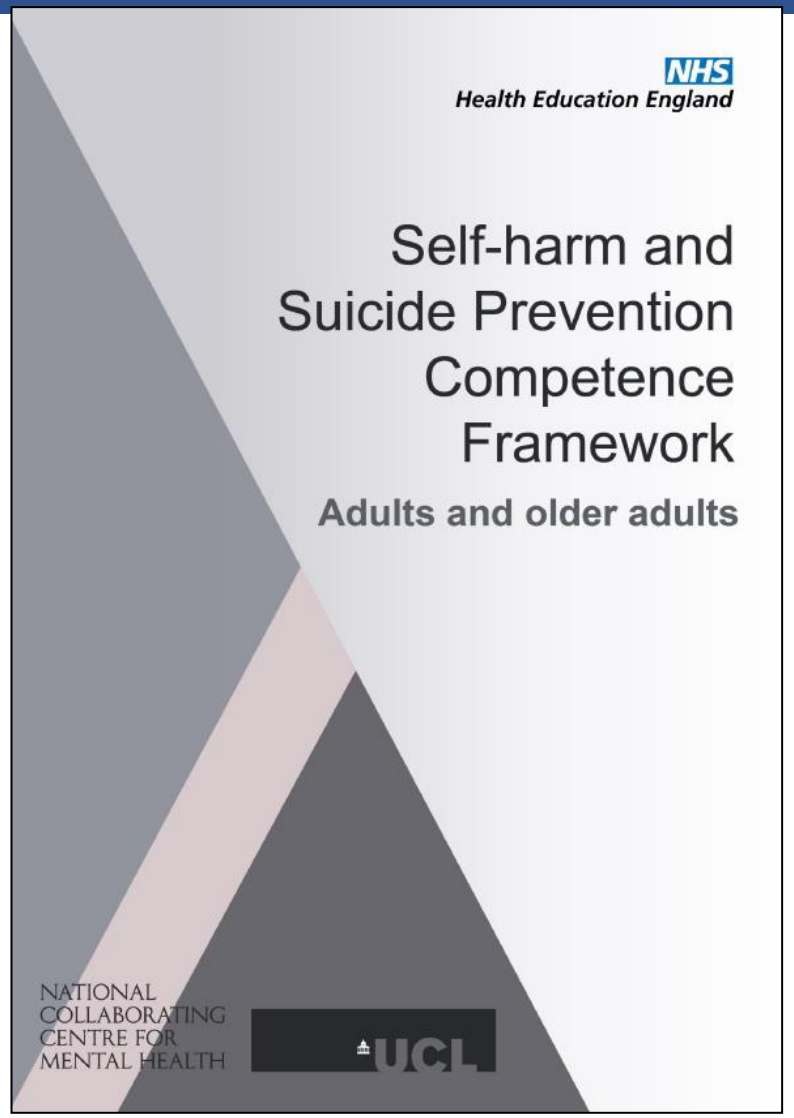
Risk of suicide increased up to **50-fold** in year after self-harm

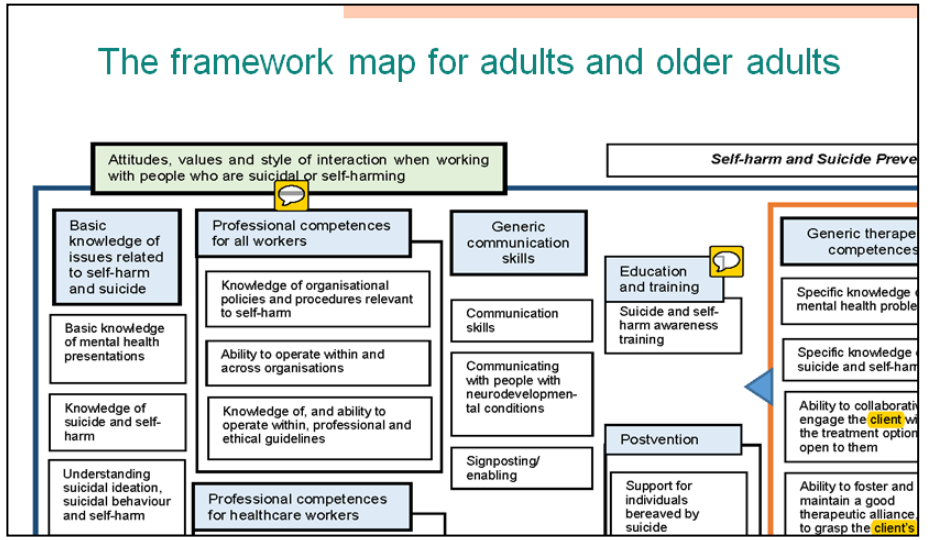
The Lancet Child & Adolescent Health DOI: (10.1016/S2352-4642(23)00126-8)

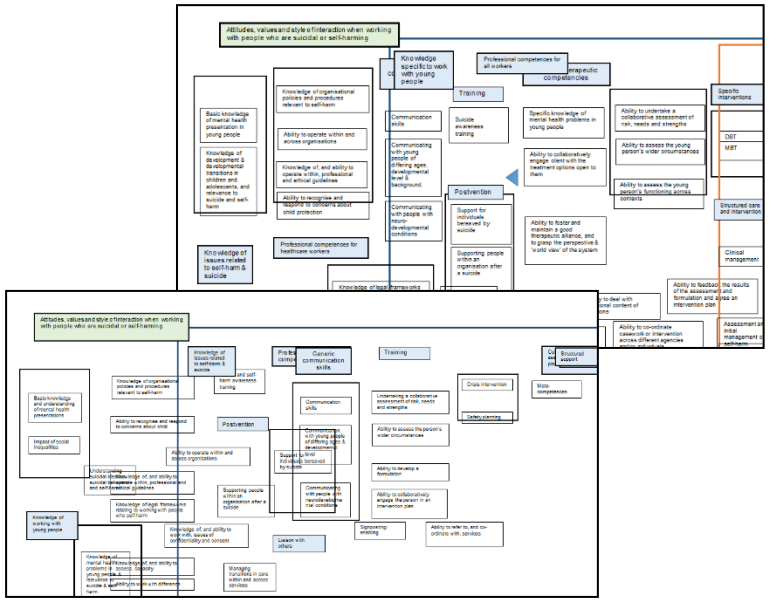
The NICE guideline

https://www.nice.org.uk/guidance/NG225

Competencies



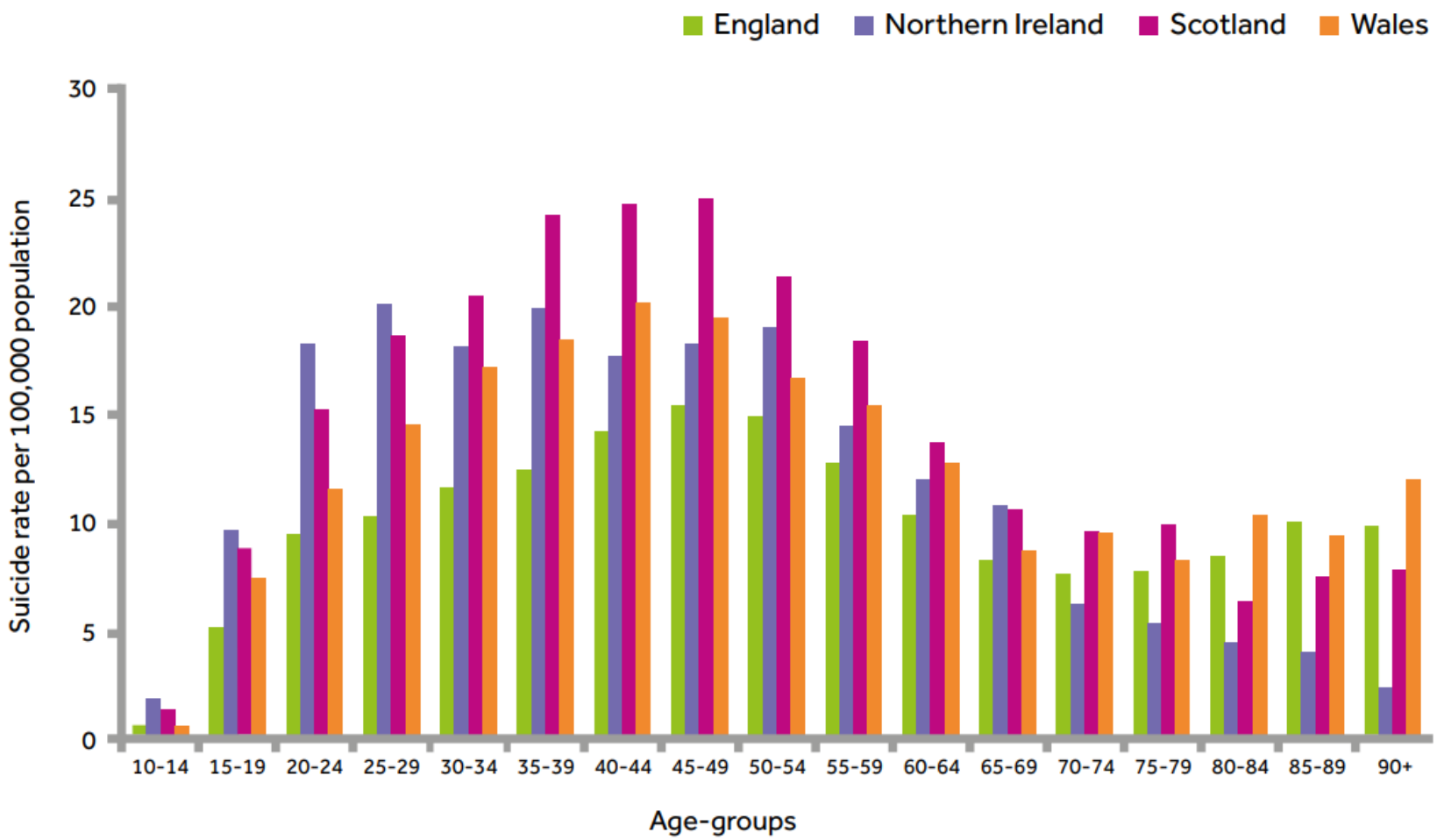




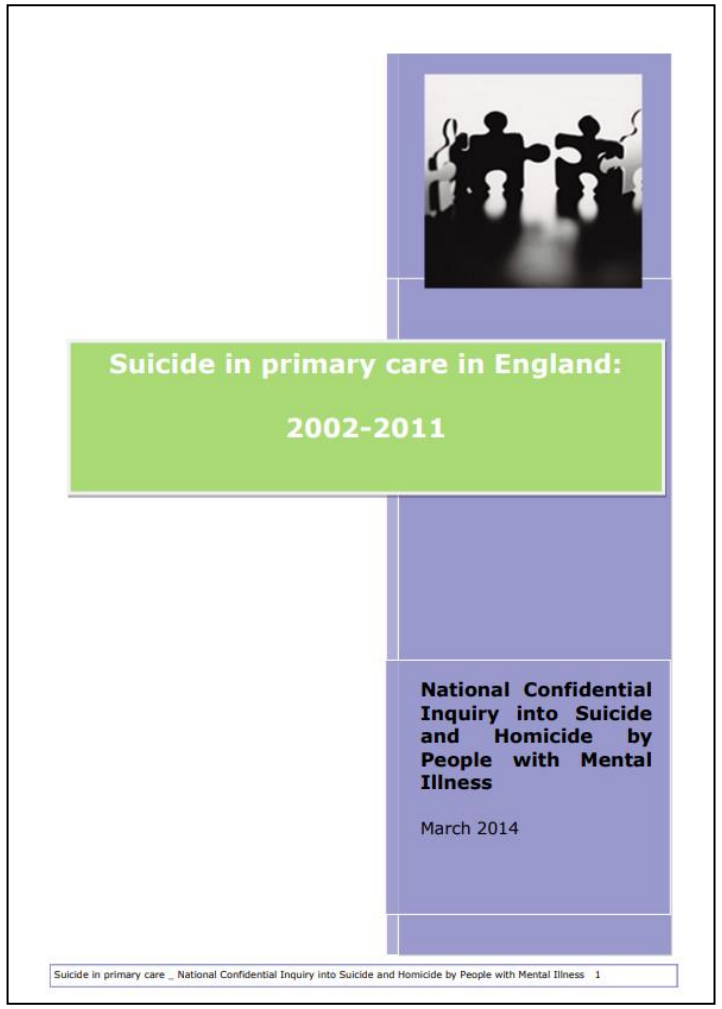
Source: UCL https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self

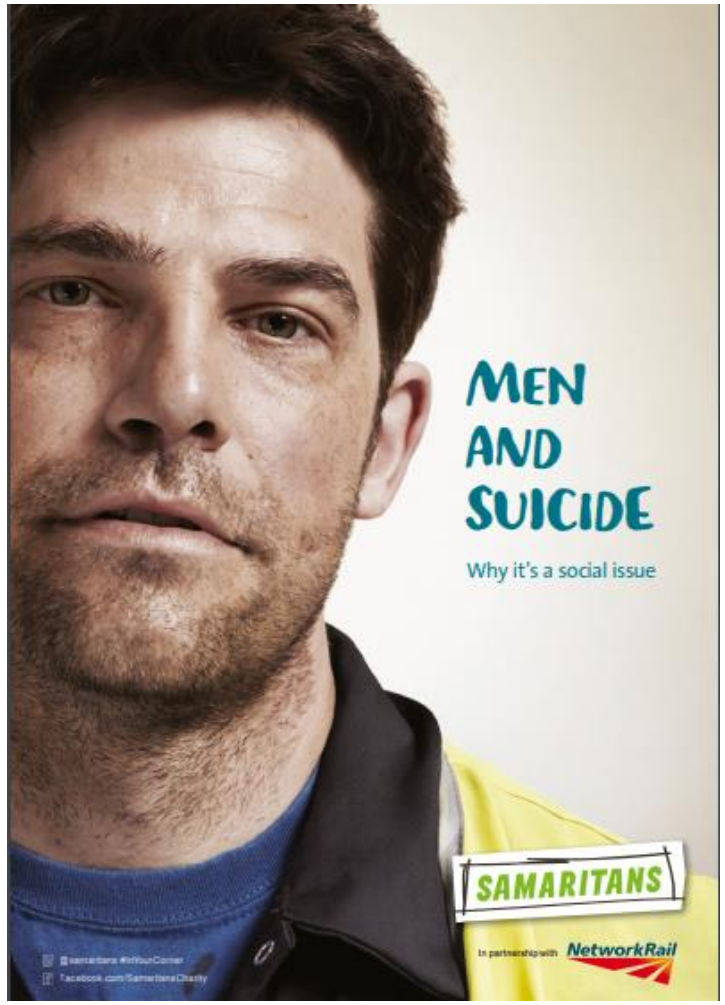
Suicide in mid life

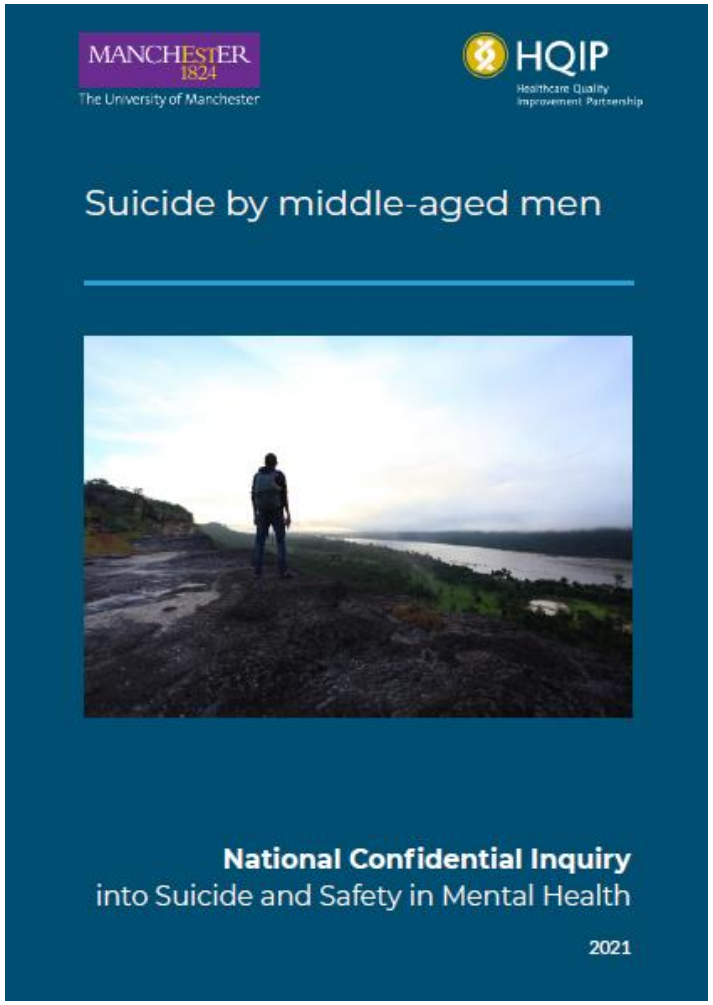
Figure 3: Suicide rates in the general population by age-group, by UK country (2011-2021)



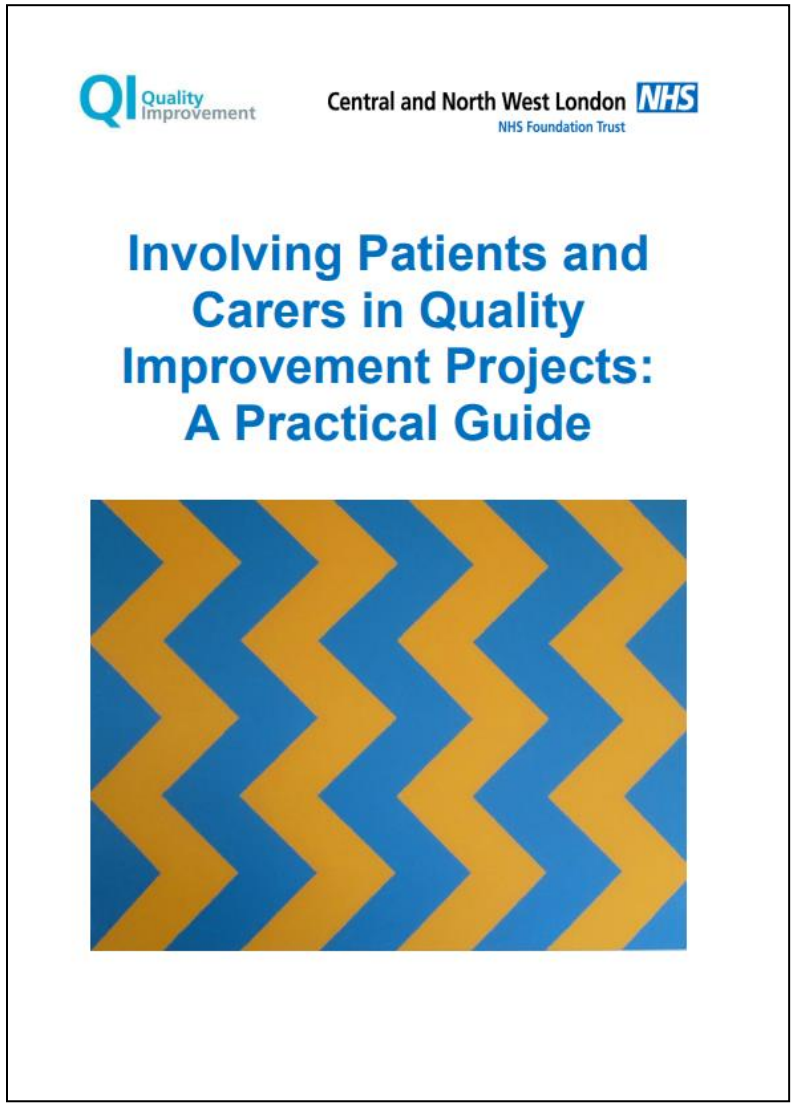
Middle-aged men







Service user and carer involvement

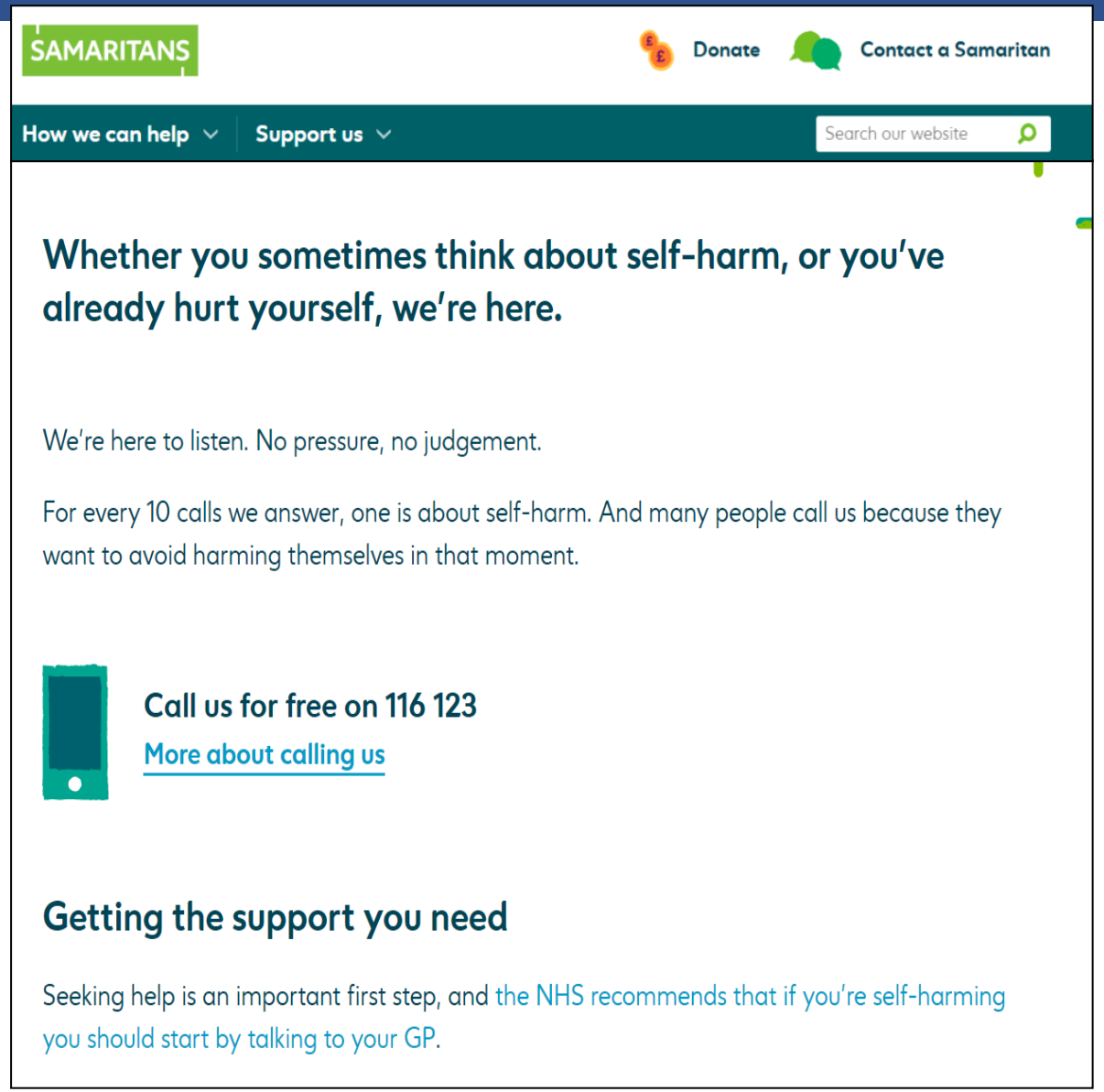



BRITISH JOURNAL OF PSYCHIATRY (2003), 183, 89–91

User and carer involvement in mental health services: from rhetoric to science

E. L. SIMPSON and A. O. HOUSE

The third sector



Source: Harmless http://www.harmless.org.uk/ ; Samaritans https://www.samaritans.org/how-we-can-help/if-youre-having-difficult-time/if-you-want-self-harm/

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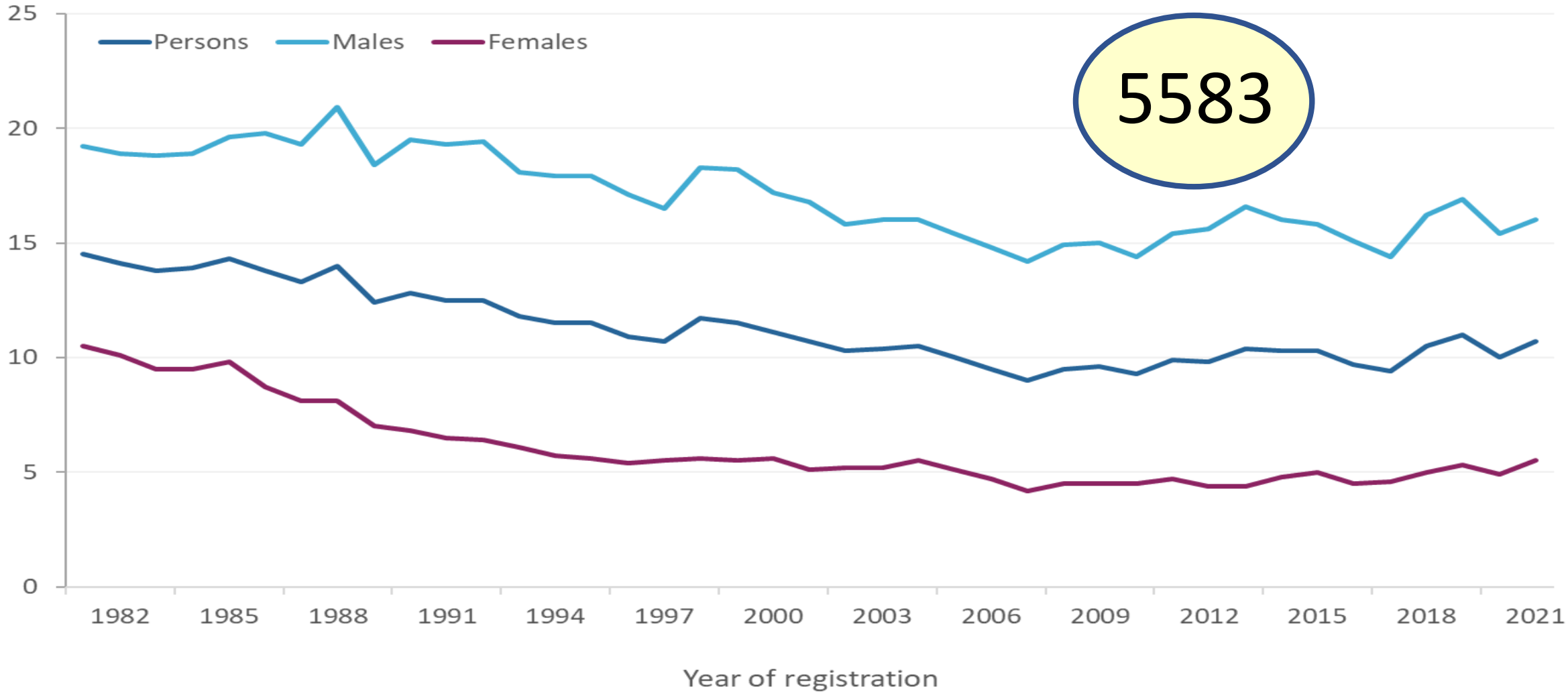
Suicide



Source: ONS

Age-standardised suicide rates by sex, England and Wales

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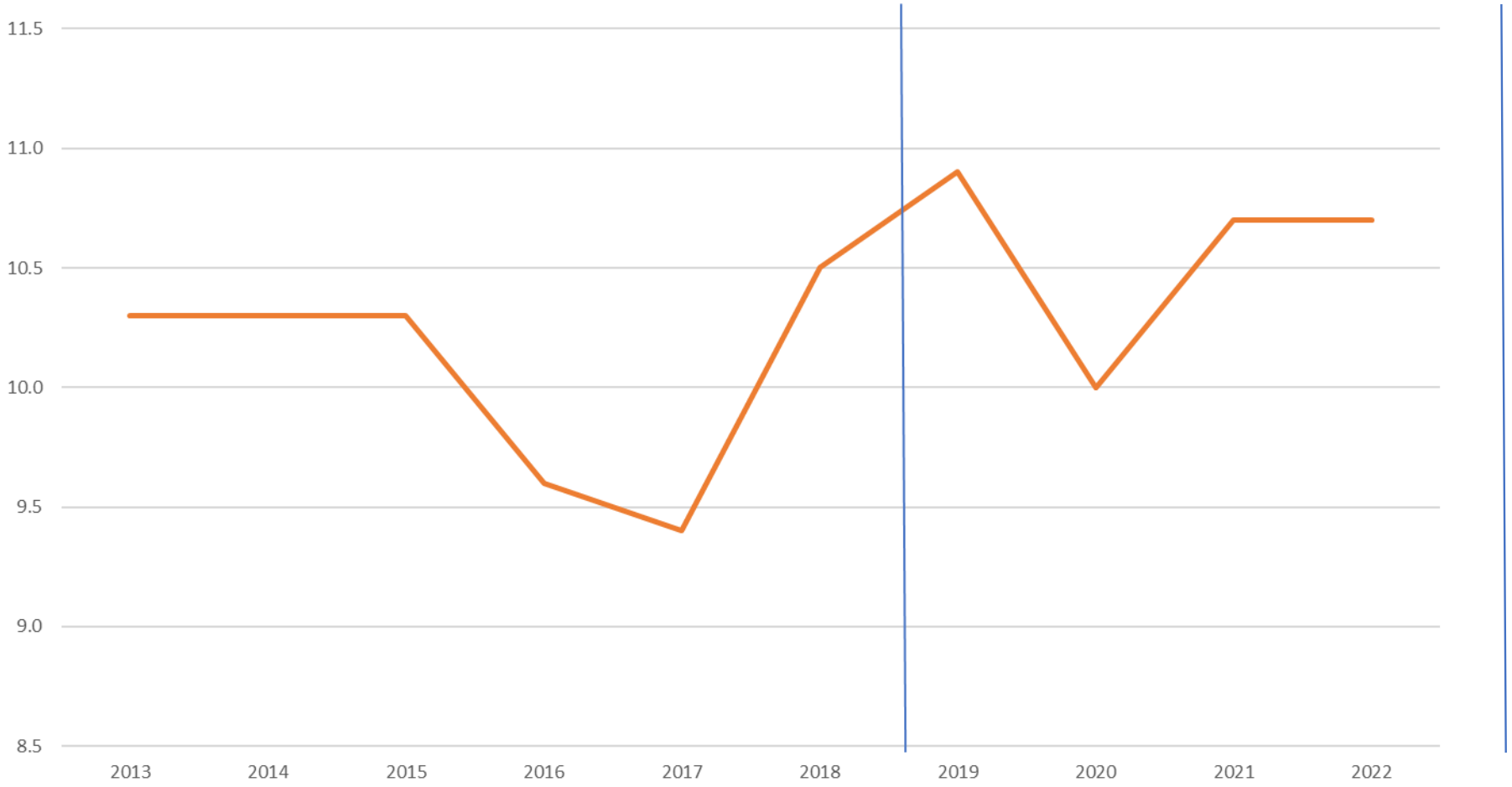
Suicide

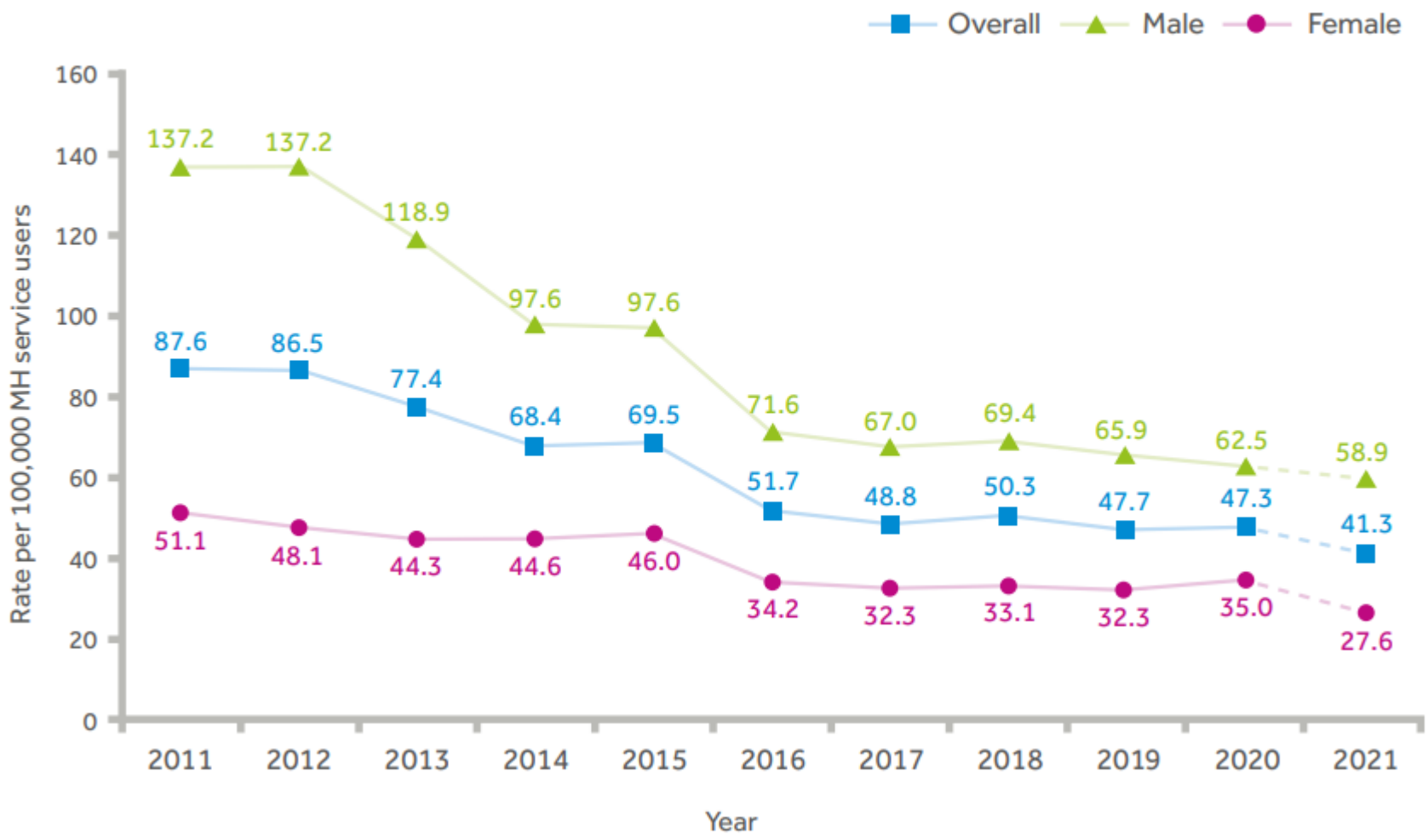


Age-standardised suicide rates by sex, England and Wales

Source: ONS

Patient suicide

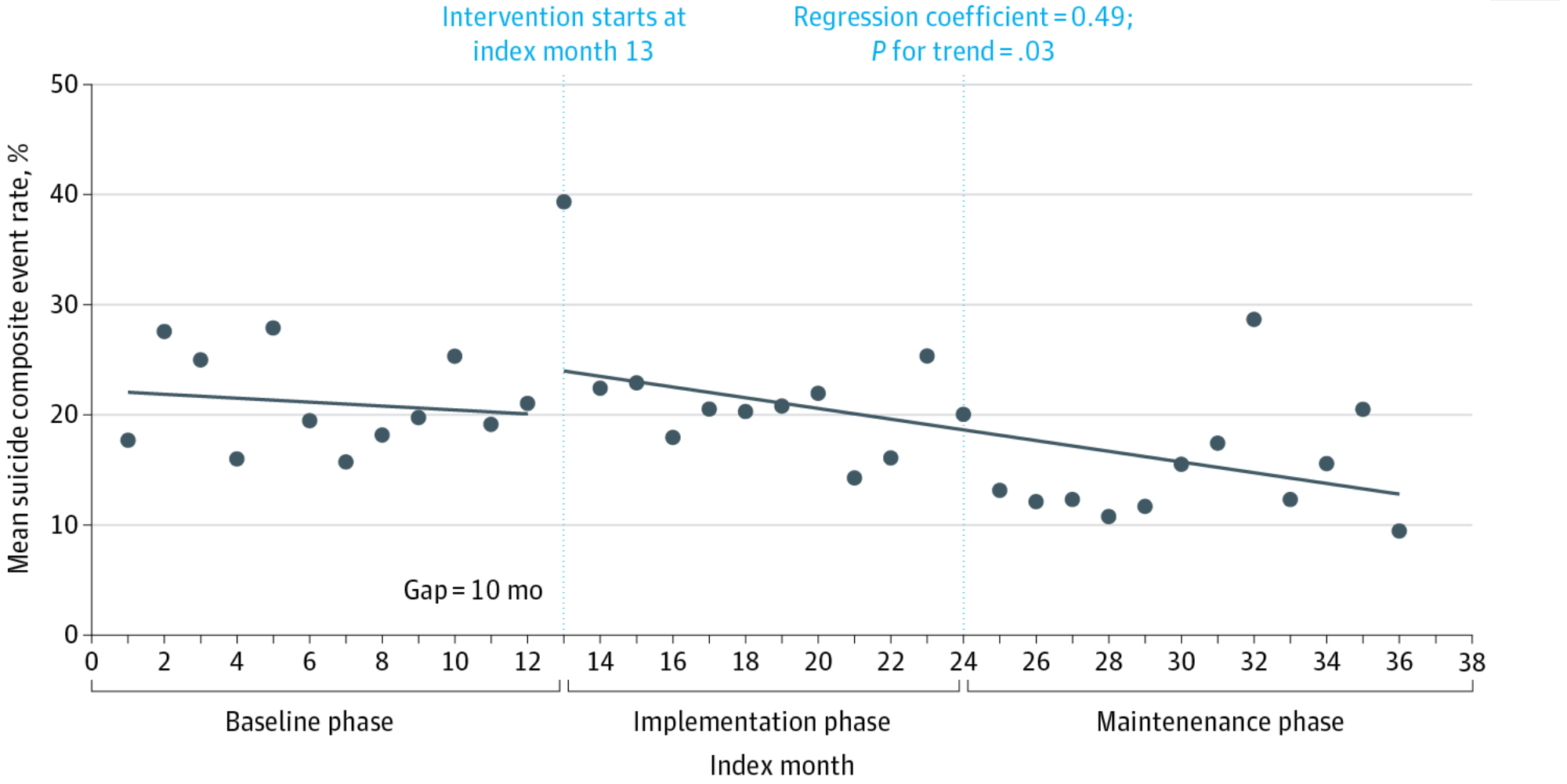
Figure 8: Rates of suicide per 100,000 mental health service users† in England



JAMA Network™

From: Effect of an Emergency Department Process Improvement Package on Suicide Prevention: The ED-SAFE 2 Cluster Randomized Clinical Trial

JAMA Psychiatry. Published online May 17, 2023. doi:10.1001/jamapsychiatry.2023.1304



“Its not just about the numbers”

Quality improvement

MindStance

mind for better mental health | Coventry and Warwickshire

cgl change, grow, live

Why did we take action?

Substance misuse is a risk factor for suicide → To join up working between services

Increase understanding of addiction & impact on mental health + Increase coping skills to improve well-being

What did we do?

6 week course → Multi-disciplinary team trained; Education; Peer support; Therapeutic conversation

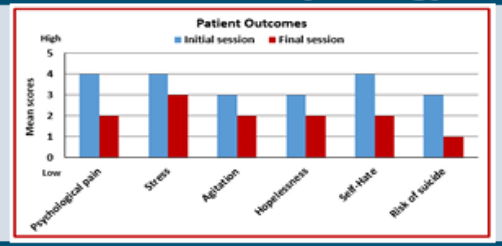
What has the impact been?

2018/2019

Increase in well-being scores; Improved insight; Improved access to support & information; Embed course in existing partnership

Coventry & Warwickshire STP

Psychiatric Liaison Suicide Prevention Psychology Pilot



Why did we take action?

High suicide risk in those who self-harm → Implement NICE guidelines following self-harm

Provide support for individuals presenting to ED + Reduce psychological distress, self-harm & suicide

What did we do?

Psychologist delivered brief intervention in GP practice → Initial contact within 7 days; engage client → Collaborative Assessment & Management of Suicide Framework → 6-10 sessions & follow-up

What has the impact been?

Mar 2019-Apr 2020

Reduction in suicidal behaviour; Improved wellbeing; Enhanced joint working (MH, 3rd sector, GPs)

Cornwall and the Isles of Scilly STP

Release the pressure: Targeted intervention to reduce suicide in men

Why did we take action?

High suicide rates in middle-aged men → Address life problems (e.g. divorce, money issues)

Increase awareness of 24/7 support-line + Increase willingness to use helpline

What did we do?

Awareness campaign: TV, radio, pubs, service stations

Mental Health Matters provide: Helpline with trained counsellors; Webchat

Shout provide: Crisis text service

What has the impact been?

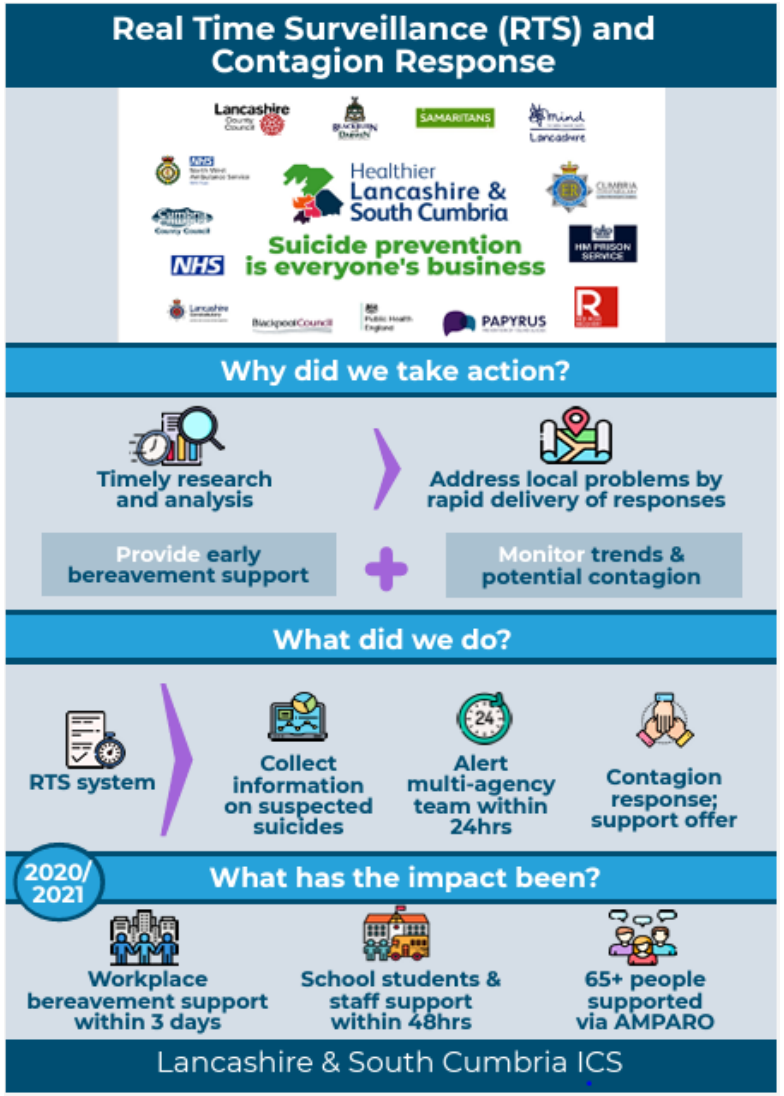
2018/2020

49,000+ calls answered; 1,500+ webchats; 45,000+ website visits

Kent and Medway STP

https://sites.manchester.ac.uk/ncish/research-projects/examples-of-good-practice-suicide-prevention-initiatives/

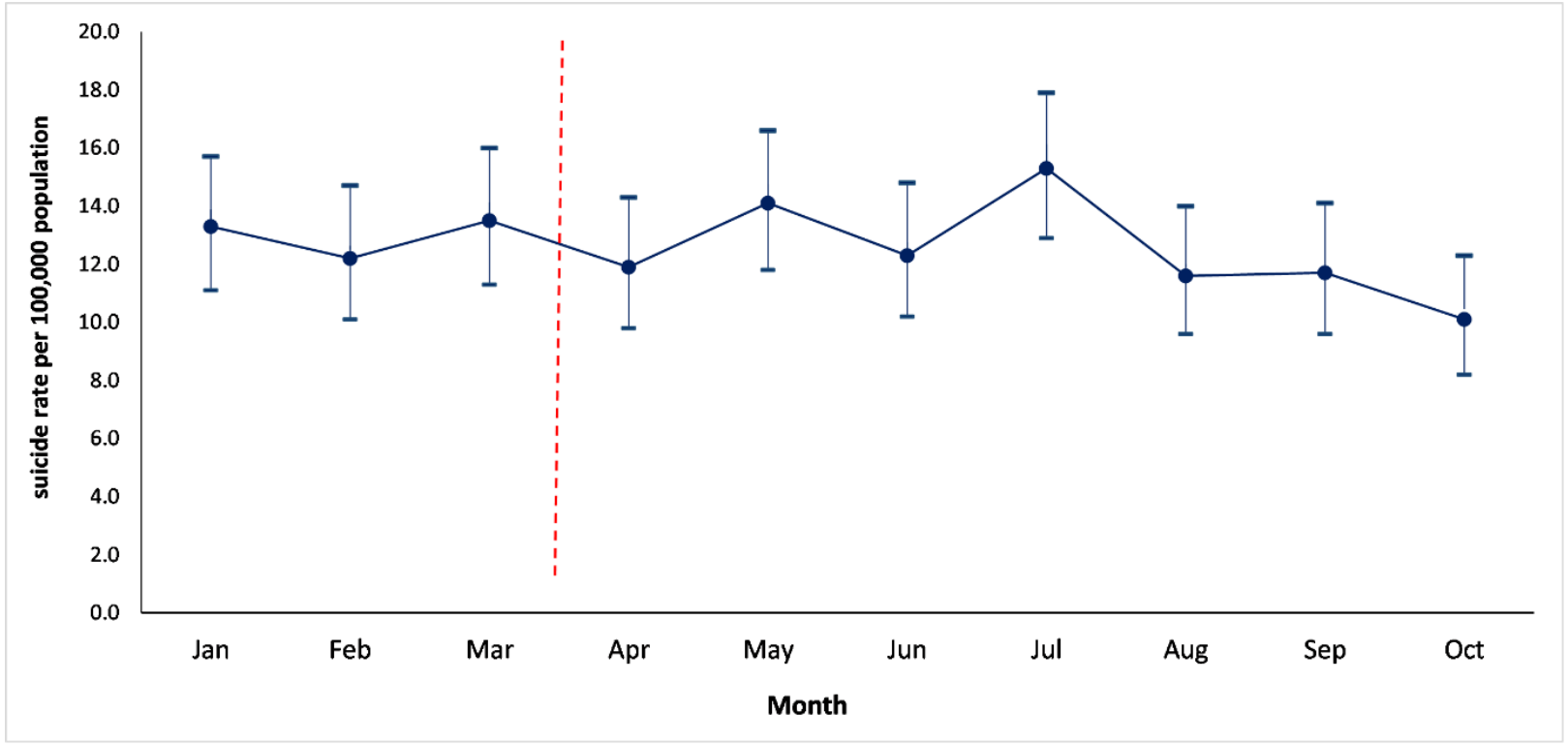
Real Time Surveillance



https://sites.manchester.ac.uk/ncish/research-projects/examples-of-good-practice-suicide-prevention-initiatives/

Suicide in England in the COVID-19 pandemic: early data from RTS

Main results



The Lancet Regional Health - Europe 000 (2021) 100110

Contents lists available at ScienceDirect

The Lancet Regional Health - Europe

journal homepage: www.elsevier.com/lanepe

Research Paper

Suicide in England in the COVID-19 pandemic: Early observational data from real time surveillance

Louis Appleby[a,*], Nicola Richards[a], Saied Ibrahim[a], Pauline Turnbull[a], Cathryn Rodway[a], Nav Kapur[a,b,c]

[a] National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), Centre for Mental Health and Safety, School of Health Sciences, University of Manchester, Manchester, United Kingdom
[b] NIHR Greater Manchester Patient Safety Translational Research Centre, Manchester, United Kingdom
[c] Greater Manchester Mental Health NHS Foundation Trust, Manchester, United Kingdom

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ABSTRACT

Background: There have been concerns that the COVID-19 pandemic may lead to an increase in suicide. The coronial system in England is not suitable for timely monitoring of suicide because of the delay of several months before inquests are held.
Methods: We used data from established systems of "real time surveillance" (RTS) of suspected suicides, in areas covering a total population of around 13 million, to test the hypothesis that the suicide rate rose after the first national lockdown began in England.
Findings: The number of suicides in April-October 2020, after the first lockdown began, was 121•3 per month, compared to 125•7 per month in January-March 2020 (-4%; 95% CI-19% to 13%, p = 0•59). Incidence rate ratios did not show a significant rise in individual months after lockdown began and were not raised during the 2-month lockdown period April-May 2020 (IRR: 1•01 [0•81 – 1•25]) or the 5-month period after the easing of lockdown, June-October 2020 (0•94 [0•81 – 1•09]). Comparison of the suicide rates after lockdown began in 2020 for the same months in selected areas in 2019 showed no difference.
Interpretation: We did not find a rise in suicide rates in England in the months after the first national lockdown began in 2020, despite evidence of greater distress. However, a number of caveats apply. These are early figures and may change. Any effect of the pandemic may vary by population group or geographical area. The use of RTS in this way is new and further development is needed before it can provide full national data.
Funding: This study was funded by the Healthcare Quality Improvement Partnership (HQIP).The HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that

No significant rise in individual months after lockdown began
Comparison of rates (2020 v 2019) showed no difference

NCISH Data Dictionary

SELF-HARM DATA			
Description	**Denominator (if applicable)**	**Baseline (if applicable)**	**Additional comments**
Rate of hospital presentations of self-harm	Office for National Statistics (ONS) mid-year population estimates (age 10 and over)	Baseline data collected prior to implementation	Local data to be taken from Emergency Departments and General Hospitals. Denominator data to be taken from Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland
Rate of self-harm admissions	Office for National Statistics (ONS) mid-year population estimates (age 10 and over)	Baseline data collected prior to implementation	Data to be taken from Hospital Episode Statistics. NB: there are caveats with using this data: https://bmjopen.bmj.com/content/6/2/e009749.

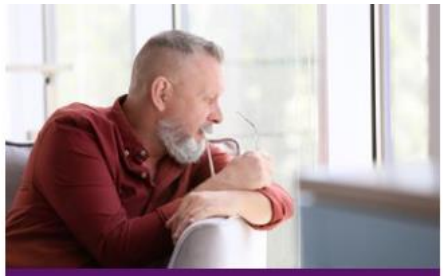
Implementation of NICE quality standards for self-harm

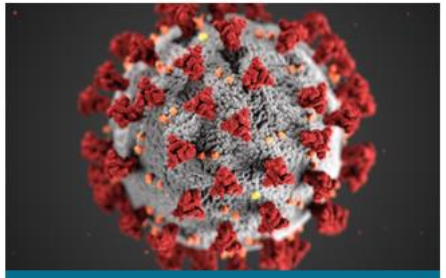
Process measures

Feedback from those receiving support after self-harm presentation to ED

Number of referrals to self-harm support service

The website





https://www.rcpsych.ac.uk/improving-care/nccmh/national-suicide-prevention-programme

https://sites.manchester.ac.uk/ncish/research-projects/

Outline

- QI for suicide prevention
- **Improving community based services for self-harm**
- CQUIN indicator for self-harm

Self-harm

Self-poisoning or self-injury irrespective of apparent motivation or medical seriousness

Self-harm

Self-poisoning or self-injury irrespective of apparent motivation or medical seriousness

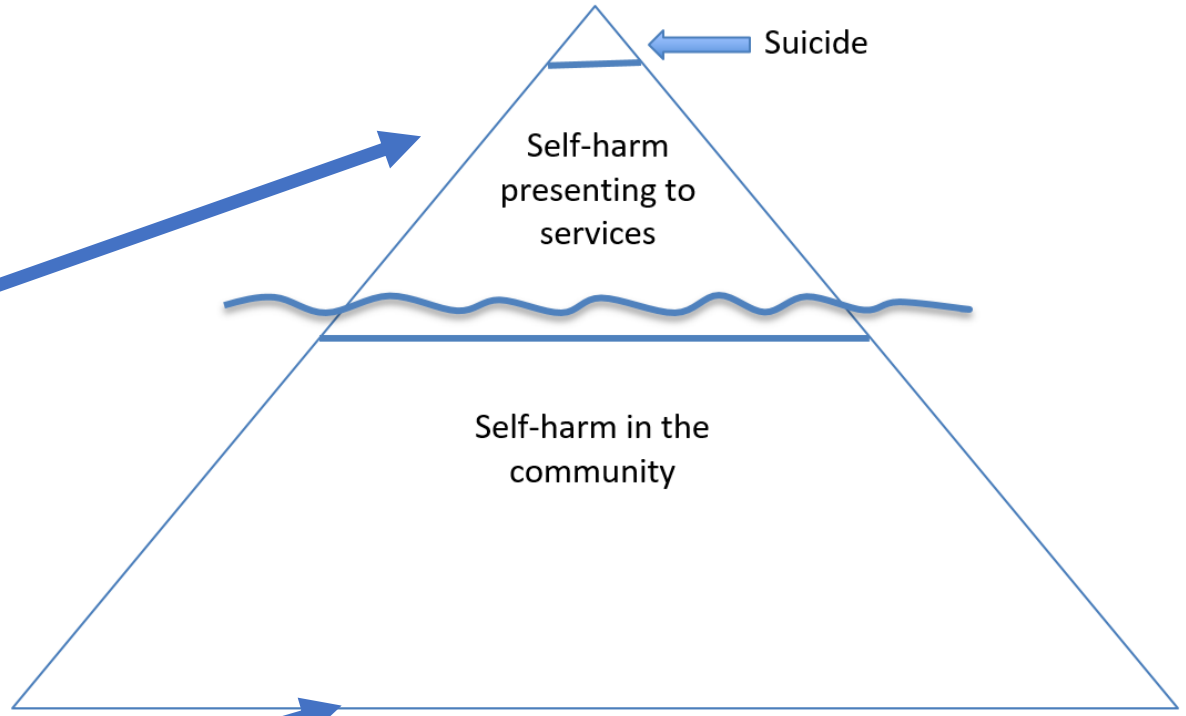
The Iceberg Model of suicidal behaviour

People on CMHT caseloads who self-harm with little access to brief psychological or other interventions

People who present to ED or MH Crisis but don't get follow up

People who present to primary care

People who don't come to the attention of services



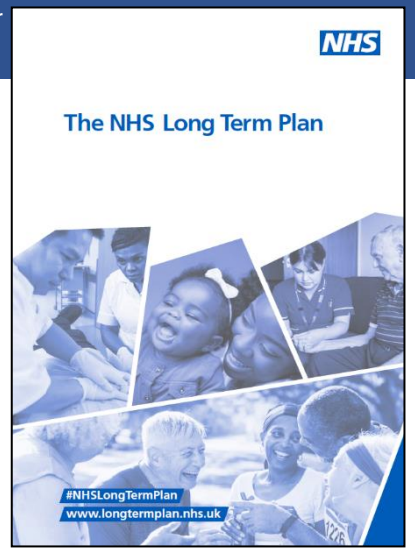
Young adults aged 18-25

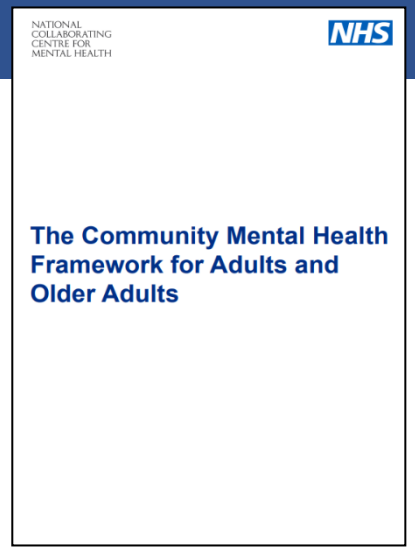
Older adults

BAME groups

LGBTQ+ groups

The NHS Long Term Plan

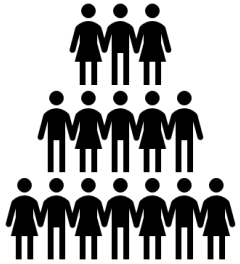




community-mental-health-framework-for-adults-and-older-adults.pdf (england.nhs.uk)

At least

370,000



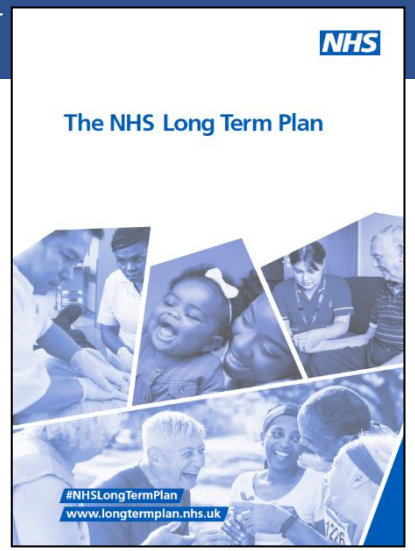
adults and older adults per year helped to access new and integrated models of primary and community mental health care by 2023/24.

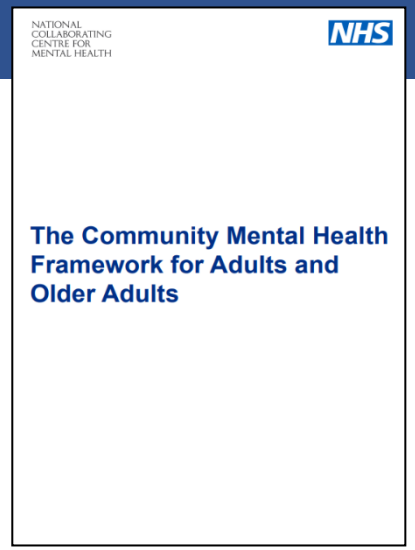
Includes - **improved self-harm support**.

£975m

extra per year

The NHS Long Term Plan





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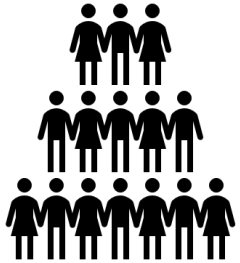

Aim: Develop plans to improve community services for self-harm.

£97.5m

extra per year

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The University of Manchester

Community based services for self-harm

HQIP
Healthcare Quality Improvement Partnership

Phase 1 and Phase 2

Support services to develop interventions

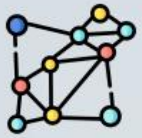
Ongoing evidence-based support

Regular support by email, phone and online meeting

Monthly interactive clinics

Patient involvement and engagement

Expert reference panel



Resources website and shared learning

Monthly virtual clinics

23 speakers on specialist topics covering:

- Patient involvement and lived experience
- Integration between services
- Safety plans and follow-up care
- Older people, minority ethnic groups, LGBTQ+

8 monthly virtual clinics

655 participants across 217 organisations

Website

Support for improving community-based care for self-harm

https://sites.manchester.ac.uk/mash-project/support-for-improving-community-based-care-for-self-harm/

Resources: evidence and guidance around self-harm

The following sections contain links to information on different aspects of care for people who self-harm, such as national clinical guidelines, peer reviewed journal publications, and commissioned reports.

We will add additional resources to this list as this project moves forward.

- Clinical guidelines on care for people who self-harm
- Guidance on psychological and medical treatment for people who self-harm
- Psychosocial assessments
- Risk assessment scales
- Promoting awareness of self-harm
- Staff training for self-harm
- Statistics about people who self-harm
- Research assessing services for self-harm
- Suicide and mortality following self-harm
- Experiences of care for self-harm
- Primary Care
- Self-harm and COVID-19
- Additional resources

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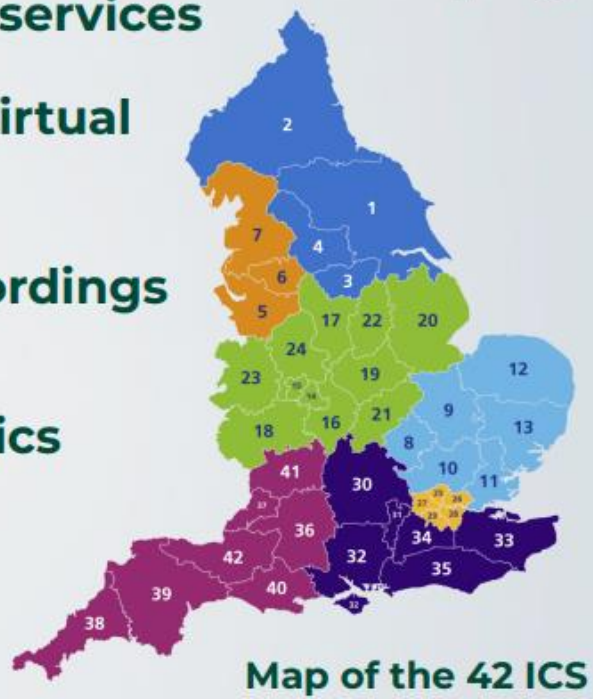
Community based services for self-harm

HQIP
Healthcare Quality Improvement Partnership

Phase 1 and Phase 2 engagement

- **42** Integrated Care Systems
- **60** million population coverage
- **959** staff and key stakeholder attendance
- **2389** views on the programme webpage
- **22** events
- **2** launch events
- **9** virtual site visits
- **22** site presentations on developing self-harm services
- **11** monthly virtual clinics
- **51** video recordings
- **7** infographics



Map of the 42 ICS

Community based self-harm

Training programme

Photo by Hannah Busing on Unsplash

Why are we taking action?

- Improve experiences for people who self-harm in the community
- Enhance the care for service users who self-harm
- Develop staff skills to support people to manage distress
- Increase awareness and understanding of self-harm

What are we planning to do?

- Develop & implement training
- Co-produced and co-facilitated
- Brief session (F2F or online) (30 MIN)
- Compassionate approach
- Personal stories

How will we measure impact?

2020/2021

- Staff attendance
- Staff survey; skills, knowledge, confidence
- Patient experience survey
- Signposting to other support services

North West London

Follow-up after attending the Emergency Department (ED) for self-harm

Why did we take action?

- Primary and secondary care have long waiting lists for patient follow-up
- Prompt follow-up by the liaison team can help support patients and strengthen care plans

What did we do?

- Established a follow-up clinic in 2014
- Patients are followed up within 72 hours of an ED presentation for self-harm

The clinic focuses on:

- Developing safety plans
- Revisiting risk assessments and discharge plans
- Offering pastoral support

What were the outcomes?

- 66% of people seen in ED attended the clinic
- COVID-19: attendance increased when phone contact replaced face-to-face sessions
- Few patients needed further secondary care

Next steps

- Improve and standardise safety planning
- Develop blended approach with face-to-face, telephone, and e-consultations
- Work collaboratively with primary care

Sunderland Psychiatric Liaison Team

https://sites.manchester.ac.uk/mash-project/support-for-improving-community-based-care-for-self-harm/

Outline

- QI for suicide prevention
- Improving community based services for self-harm
- **CQUIN indicator for self-harm**

CQUIN for self-harm

CCG12: Biopsychosocial assessments by MH liaison services

Description	Achieving 80% of self-harm[7] referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	
Numerator	Of the denominator, those that had evidence of a comprehensive biopsychosocial assessment concordant with Section 1.3 of CG133 including: • Assessment of needs • Risk assessment • Developing an integrated care and risk management plan[8]	
Denominator	The total referrals for self-harm to liaison psychiatry.	
Exclusions	N/A	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Mental health liaison teams	Period: All quarters
Payment basis	Minimum: 60% Maximum: 80%	Calculation: Quarterly average %

https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/

CQUIN for self-harm

CQUIN for psychosocial assessment

Launch events

Ongoing evidence-based support

CQUIN audit tool

Quarterly interactive clinics

FutureNHS collaboration platform

CQUIN engagement

- **550** staff and key stakeholder attendance
- **172** Emergency Departments with Mental Health Liaison Teams represented
- **1** launch event
- **3** implementation support events
- **1** psychosocial assessment audit tool
- **2** support documents (FAQ, Guidance)

www.manchester.ac.uk/ncish www.manchester.ac.uk/mash www.patientsafety.manchester.ac.uk

CQUIN for self-harm

East Surrey Hospital Liaison Psychiatry Service, SABP

What did we achieve in the first six months?

- 84.8% of referrals receiving a biopsychosocial assessment
- Increased quality of assessments
- Increased quality of GP letters
- Increase in copies of GP letters sent to patients

Next steps

2022/2023

- Involve carers
- Improve risk assessments
- Use a trauma-informed approach to assessment
- Roll out template to all psychiatric liaison teams

CQUIN Performance

Average annual performance – 85%

Region	Submissions	Unique submissions	Q1	Q2	Q3	Q4	Average	>= 60%	>= 80%
East of England	111	99	89%	89%	91%	87%	89%	4	4
London	148	134	84%	92%	89%	89%	89%	6	4
Midlands	197	185	73%	82%	83%	93%	83%	10	8
North East and Yorkshire	205	182	88%	89%	91%	86%	89%	9	8
North West	131	122	86%	89%	93%	92%	90%	4	4
South East	145	135	90%	95%	96%	94%	94%	6	6
South West	114	101	90%	92%	98%	95%	94%	4	2
ENGLAND	**1051**	**958**	**81%**	**85%**	**88%**	**88%**	**85%**	**43**	**36**

Outline

- QI for suicide prevention
- Improving community based services for self-harm
- CQUIN indicator for self-harm

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Centre for Mental Health and Safety

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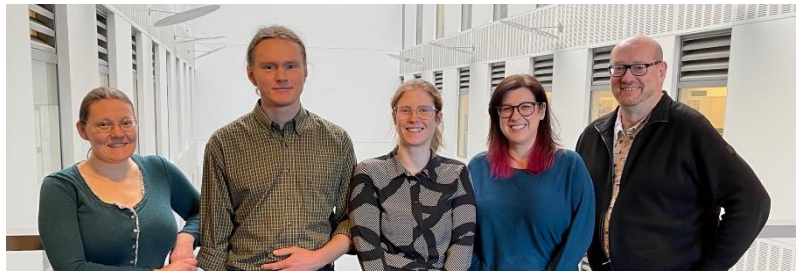


NCISH

@NCISH_UK

The Manchester Self-Harm Project

@mashproject

NIHR | Greater Manchester Patient Safety Translational Research Centre

@PSRC_GM

Sharing good practice in suicide prevention and learning from the Suicide Prevention Programme

NCISH

IMPROVING MENTAL HEALTH SAFETY
National Suicide Prevention

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

UCL

Sharing good practice

- **Complete your poster (15min)** – copies are available from the team
- **Display your completed poster (10min)**
- **Time to review posters around the room (30min)**
- **Whole room discussion and reflections (20min)**

NCCMH

Name:
Organisation:

IMPROVING MENTAL HEALTH SAFETY
Self harm and suicide prevention

What is something you've worked on in suicide prevention that you are most proud of?

What idea(s) have you taken from others?

What have you learnt about doing this work that you'd like to share?

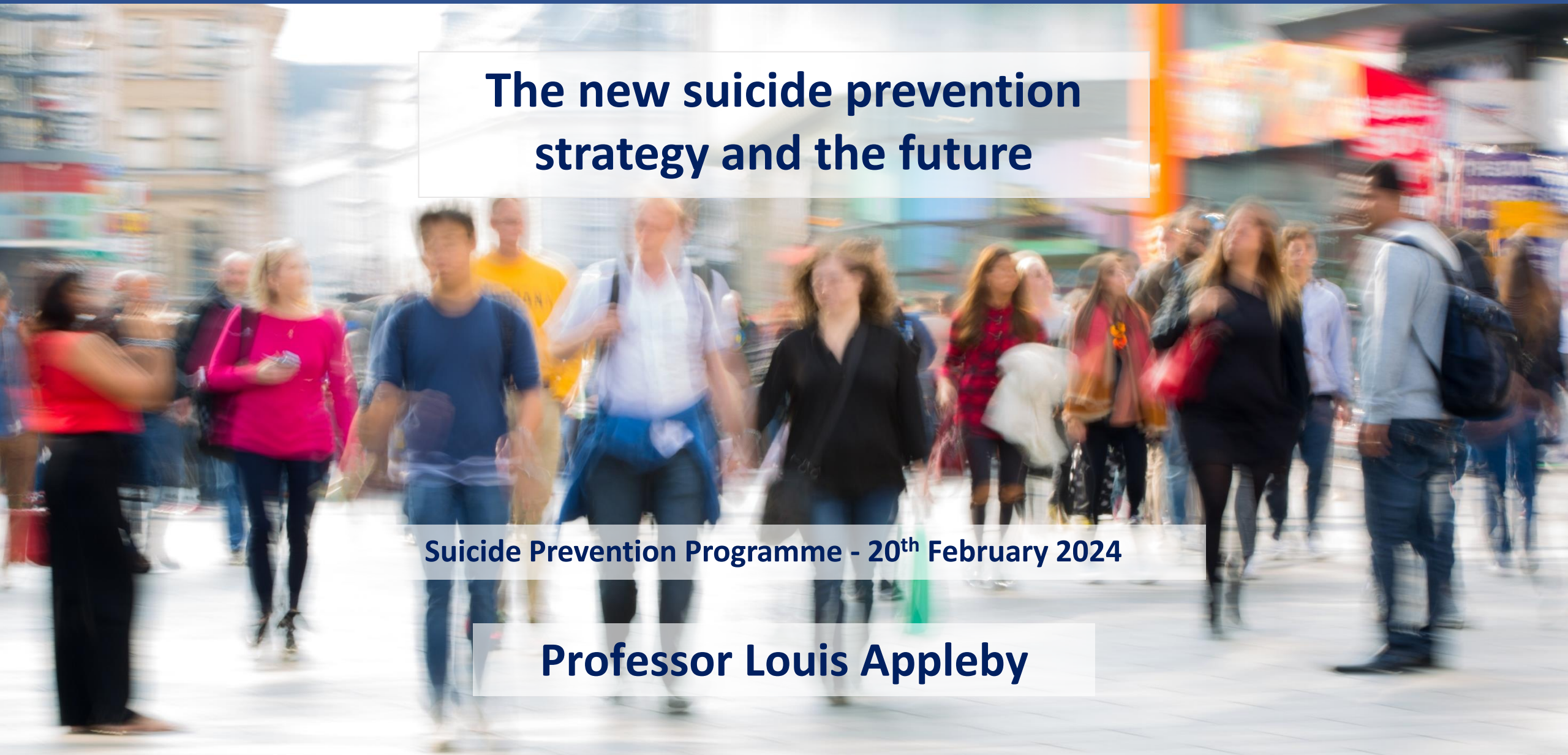
#SuicidePreventionProgramme

The new suicide prevention strategy and the future

Professor Sir Louis Appleby

Director of NCISH, Professor of Psychiatry

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)



The new suicide prevention strategy and the future

Suicide Prevention Programme - 20th February 2024

Professor Louis Appleby

Suicide prevention strategy 2023

Improve data & evidence

Support priority groups

Address population risk factors

Online safety & responsible media

Effective crisis care

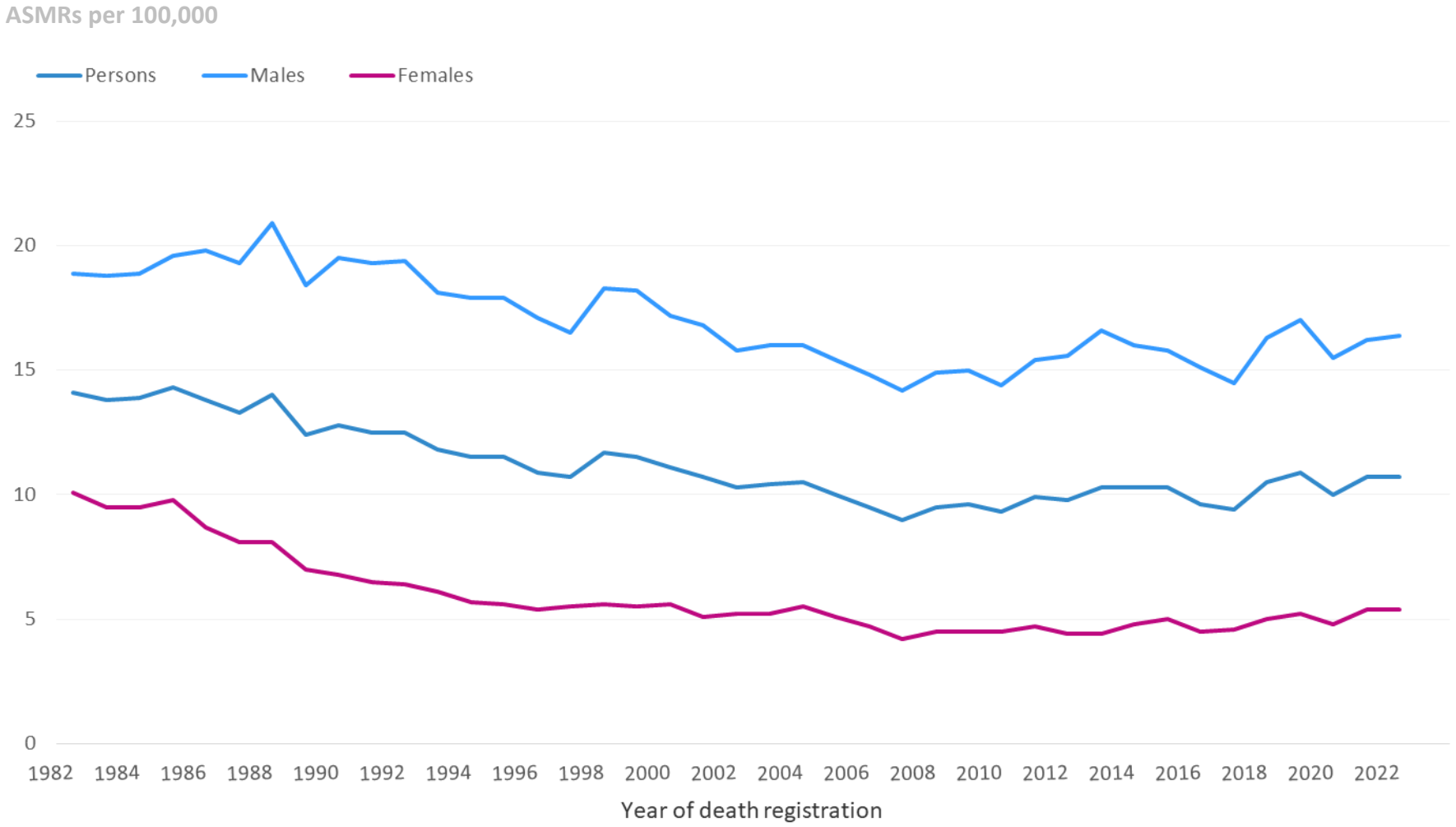
Reduce access to methods of suicide

Suicide bereavement support

Make suicide everybody's business

Suicide rates registered, England and Wales 1982-2022

Age-standardised suicide rates by sex, England and Wales, registered



Rates in 2007 and 2017 lowest on record

Covid disruption 2020-2021

No overall change since 2018

Source: ONS

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Quarterly suicide rates, 2014-22, England

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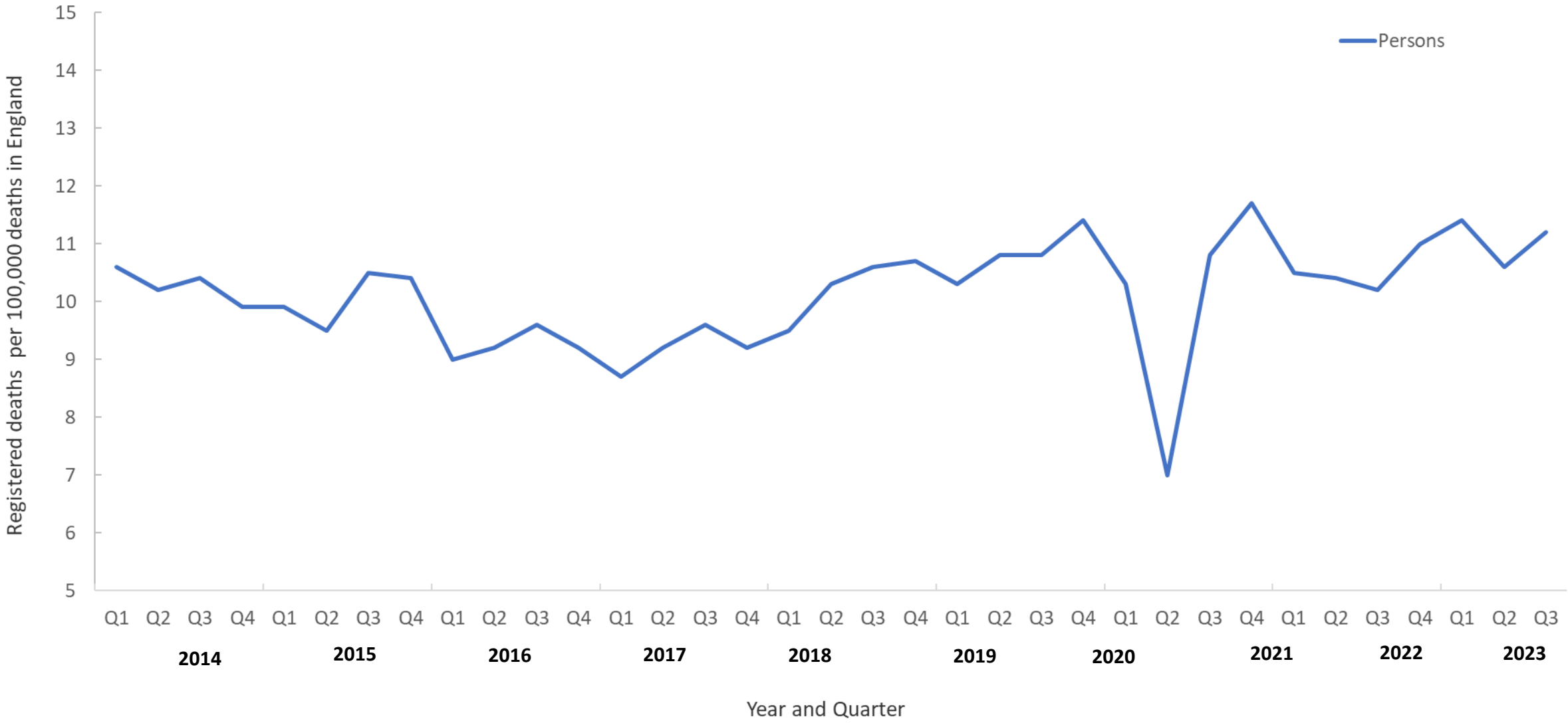
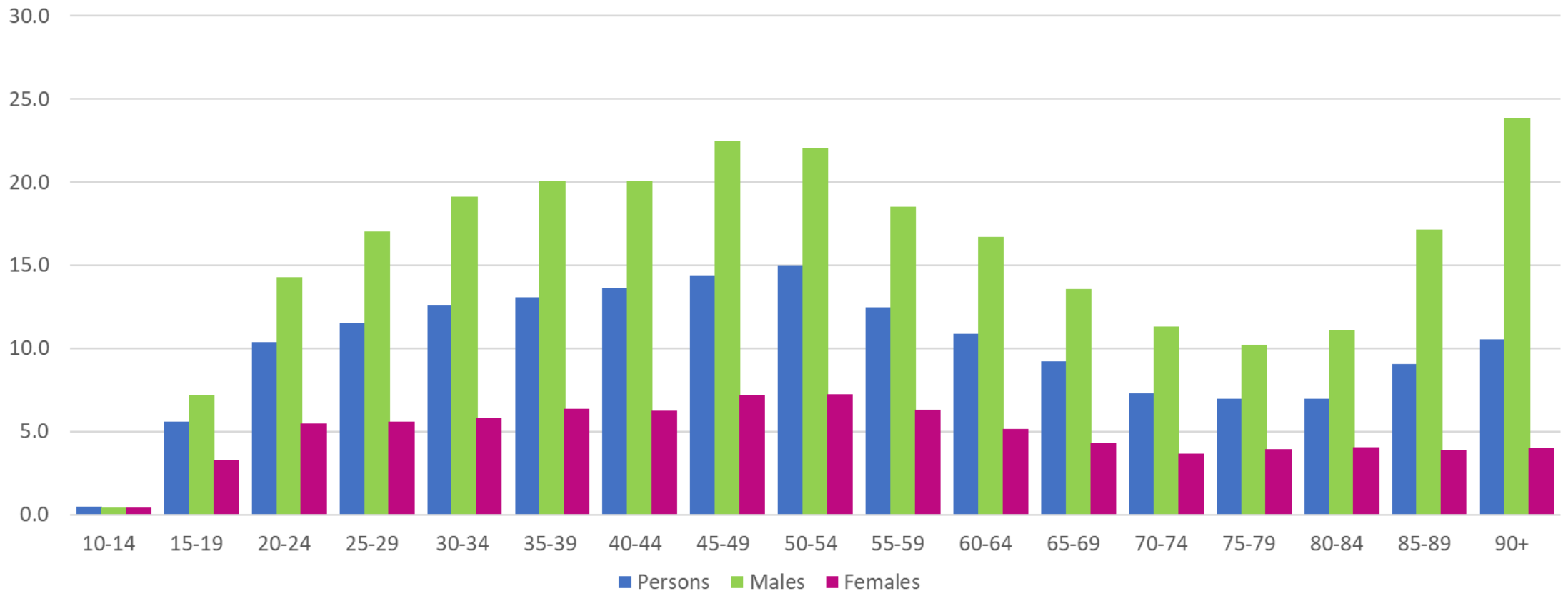


Source: ONS

Suicide in age and sex groups

Age-specific suicide rates, 3-year average 2020-2022, England



Men aged **45-54 and 90+** have highest suicide rates

Source: ONS Suicides in England and Wales: 2022 registrations

Suicide in middle-aged men: national study

Original research

BMJ Public Health

Antecedents and service contact in an observational study of 242 suicide deaths in middle-aged men in England, Scotland and Wales, 2017

Jane Graney ,[1] Saied Ibrahim,[1] Su-Gwan Tham ,[1] Pauline Turnbull,[1] Louis Appleby,[1] Nav Kapur,[1,2,3] Cathryn Rodway[1]

To cite: Graney J, Ibrahim S, Tham S-G, *et al*. Antecedents and service contact in an observational study of 242 suicide deaths in middle-aged men in England, Scotland and Wales, 2017. *BMJ Public Health* 2024;**2**:e000319. doi:10.1136/bmjph-2023-000319

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjph-2023-000319).

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[1]University of Manchester, Manchester, UK
[2]Mersey Care NHS Foundation Trust, Liverpool, UK
[3]NIHR Greater Manchester Patient Safety Research Collaboration, Manchester, UK

ABSTRACT

Introduction Middle-aged men are the demographic group at highest risk of dying by suicide. We conducted a national study of deaths by suicide in men in mid-life to investigate the stresses they face before they take their lives and their contact with services that could be preventative.

Methods This study is a detailed descriptive examination of suicide in a sample of men aged 40–54 who died by suicide in England, Scotland and Wales in 2017, based on national mortality data. We extracted information on the antecedents of suicide from official investigations, mainly coroner inquests and police death reports.

Results In 2017, there were 1516 suicides by middle-aged men, representing 25% of all suicide deaths. Of the 288 suicide deaths in middle-aged men randomly selected for review, we obtained data about antecedents on 242 (84%). Many were unmarried (161, 67%). We found a complex pattern of stresses and recent adversity before suicide including economic adversity (139, 57%), physical ill-health (125, 52%), self-harm (106, 44%), alcohol and/or drug misuse (119, 49%), and bereavement (82, 34%; including by suicide, 14, 6%). Most men (220, 91%) had known contact with healthcare, justice system or other support services—67% (n=162) in the previous 3 months, 38% (n=91) in the previous week. Contact with multiple agencies was reported for 17% of men.

Conclusions A mix of long-standing and recent risks contribute to suicide risk in men in mid-life. Economic stresses, including unemployment, financial and housing problems, are particularly important factors in this group. Contrary to our expectations, most men were in contact with support services. Economic support (especially at a time of severe economic pressure), addressing isolation, joint working with the voluntary sector, and addressing specific stresses, such as bereavement, may help reduce risk.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ In the UK, middle-aged men have the highest suicide rate, but there are few national studies examining the antecedents of suicide in this group.

WHAT THIS STUDY ADDS

⇒ We identified multiple stresses and recent adversities in middle-aged men who died by suicide. Several factors, such as mental and physical illness and alcohol misuse, confirm associations with suicide from previous research and are important to prevention in this group. Other antecedents, such as a history of violence and online harms we found in more men than expected.

⇒ We found evidence of much more help-seeking than expected, including in the week prior to death, with many men having been in contact with a range of services or agencies, mainly their general practitioner. This differs from previous studies and a commonly accepted notion that men do not seek help.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Services can contribute to suicide prevention in middle-aged men by improving recognition of risk when men present to services and by ensuring appropriate support tailored to their needs is available and accessible.

⇒ Recognition of financial stresses, and signposting to employment and debt advice and housing support, is also an important part of suicide prevention. Given the current global cost of living crisis and the increased burden this has historically placed on men, a suicide prevention priority must be to offer and maintain economic protections to groups we know to be vulnerable to economic adversity.

INTRODUCTION

Worldwide, male suicide rates are three

the UK, the USA, Australia, Canada and many other high-income countries, middle-aged men have the highest suicide rates.[2–6]

We found high rates of

- economic adversity
- physical ill-health
- alcohol/drugs

Most had recent contact with services - simplistic to say men don't seek help.

Source: Graney J, Ibrahim S, Tham SG, Turnbull P, Appleby L, Kapur N, Rodway C. Antecedents and service contact in an observational study of 242 suicide deaths in middle-aged men in England, Scotland and Wales, 2017. BMJ Public Health. 2024 Jan 1;2(1).

Sociodemographic inequalities of suicide

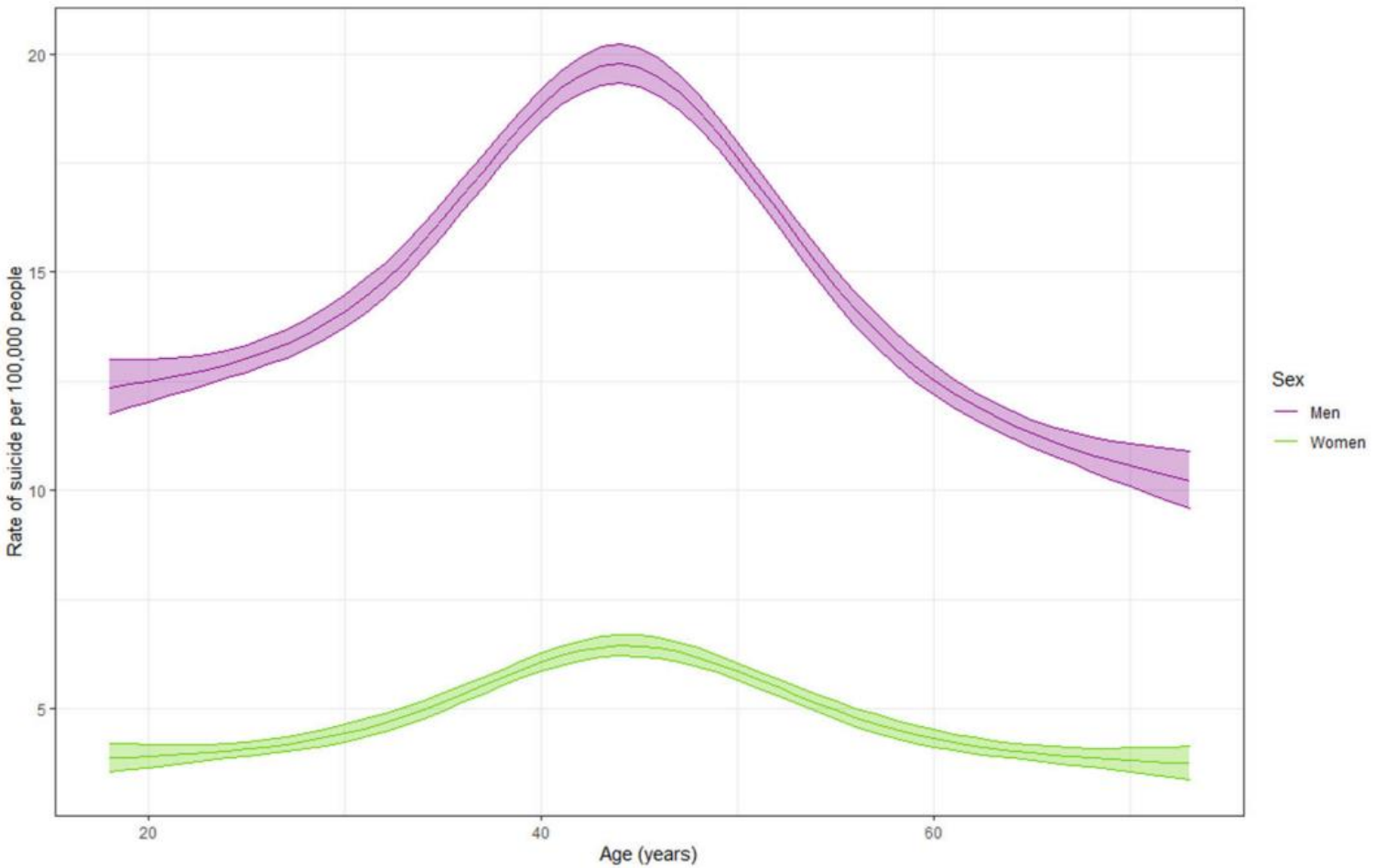


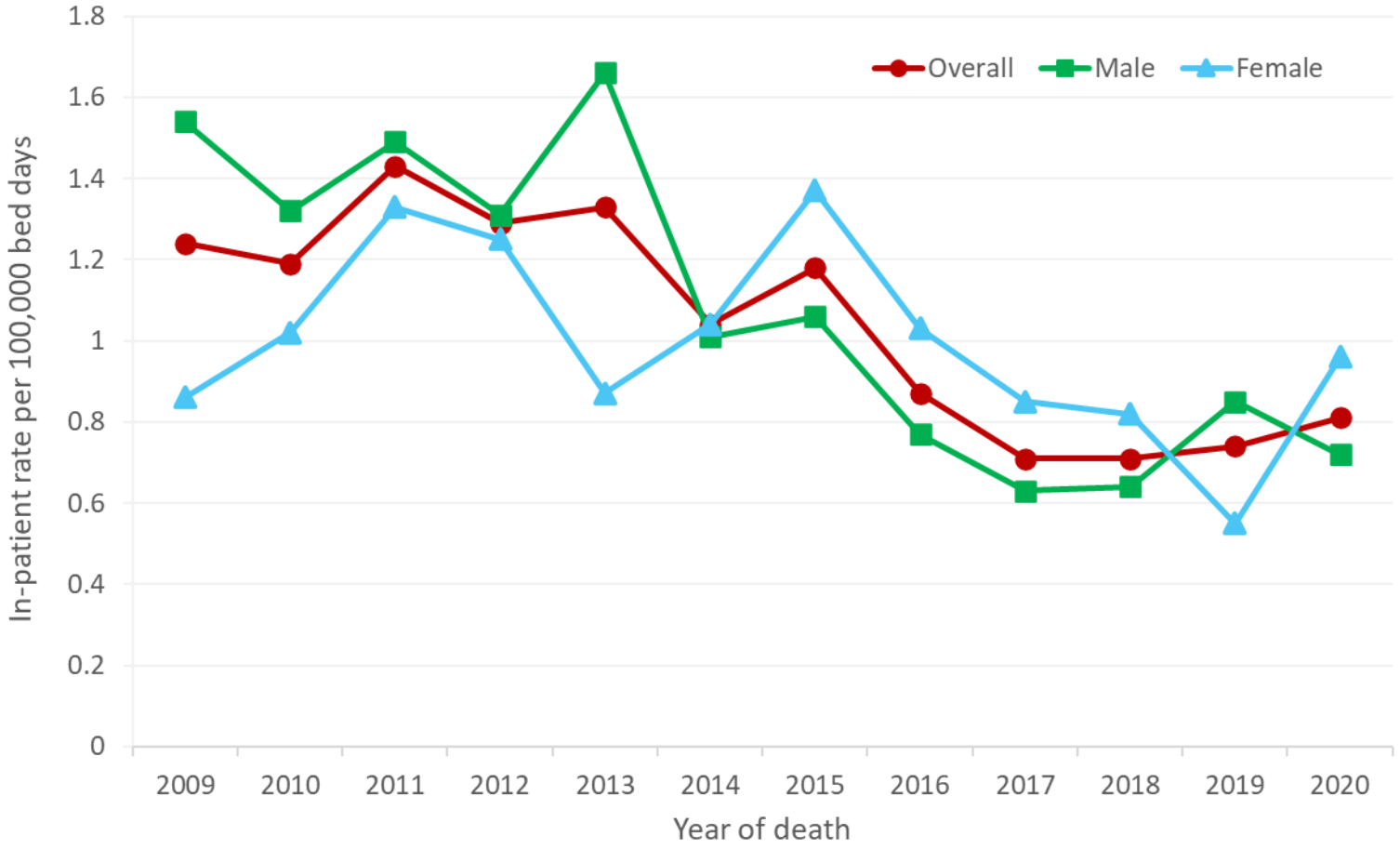
Figure 1 Estimated rates of suicide per 100 000 people by age and sex. Estimated rates of suicide per 100 000 people by age and sex from a Poisson model. Age was interacted with sex. Age was included as a natural spline with boundary knots at the 1st and 99th percentiles and four internal knots

Main effects were in:

- Age
- Sex
- Health & disability
- Long-term unemployment

Source: Ward, I.L., Finning, K., Ayoubkhani, D., Hendry, K., Sharland, E., Appleby. L., Nafilyan, V. Sociodemographic inequalities of suicide: a population-based cohort study of adults in England and Wales 2011–21, European Journal of Public Health, 2024, https://doi.org/10.1093/eurpub/ckad233

Psychiatric in-patient care in England: as safe as it can be?



Falling inpatient suicide rates over the last decade:

- fall started several years earlier - this is a long-term trend
- seems to have levelled off since 2016
- less apparent in younger patients.

Source: Hunt IM, Baird A, Turnbull P, Ibrahim S, Shaw J, Appleby L, Kapur N. Psychiatric in-patient care in England: as safe as it can be? An examination of in-patient suicide between 2009 and 2020. Psychological Medicine. 2024 Jan 12:1-7.

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10 evidence-based ways to improve safety in MH care

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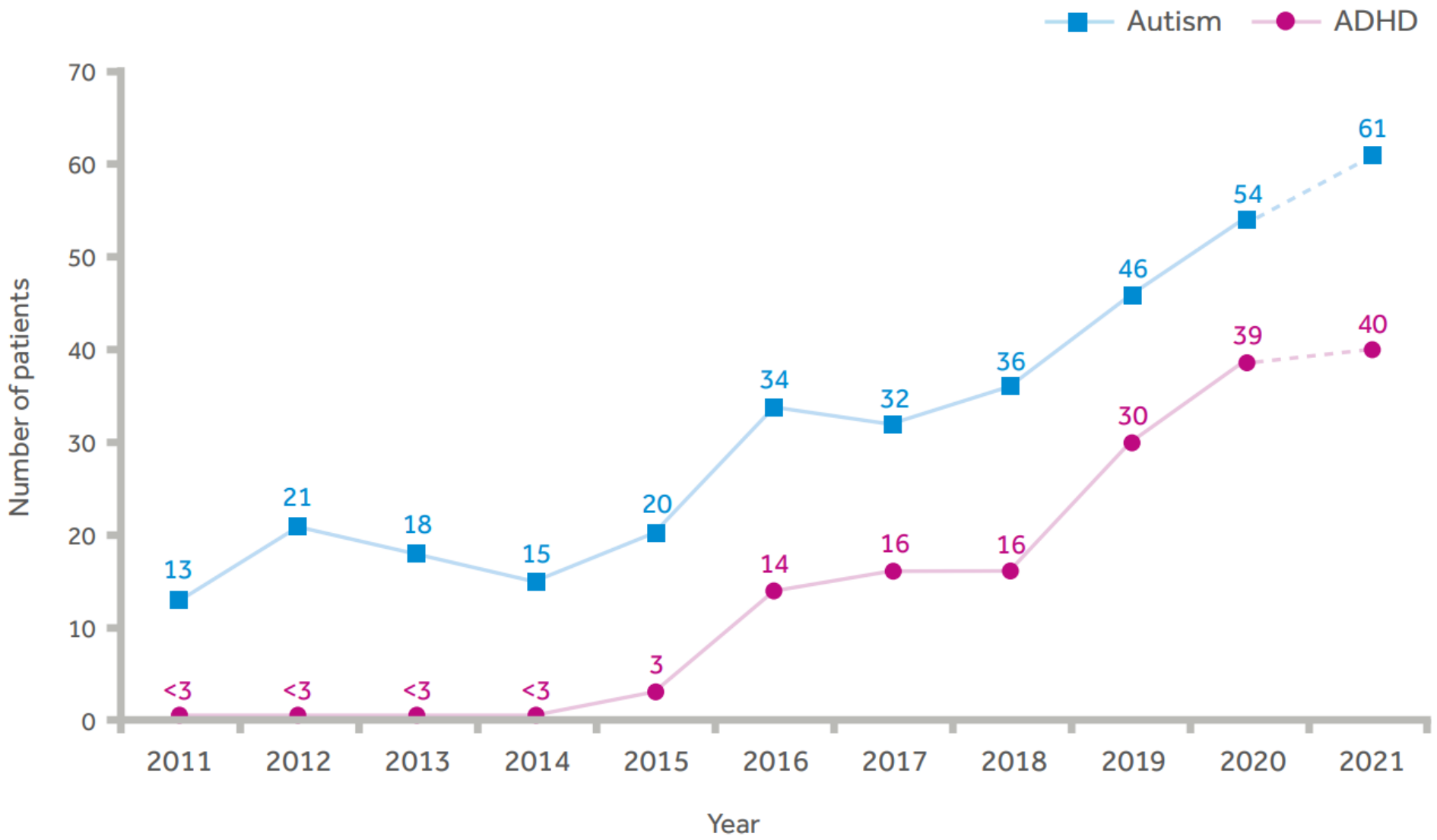
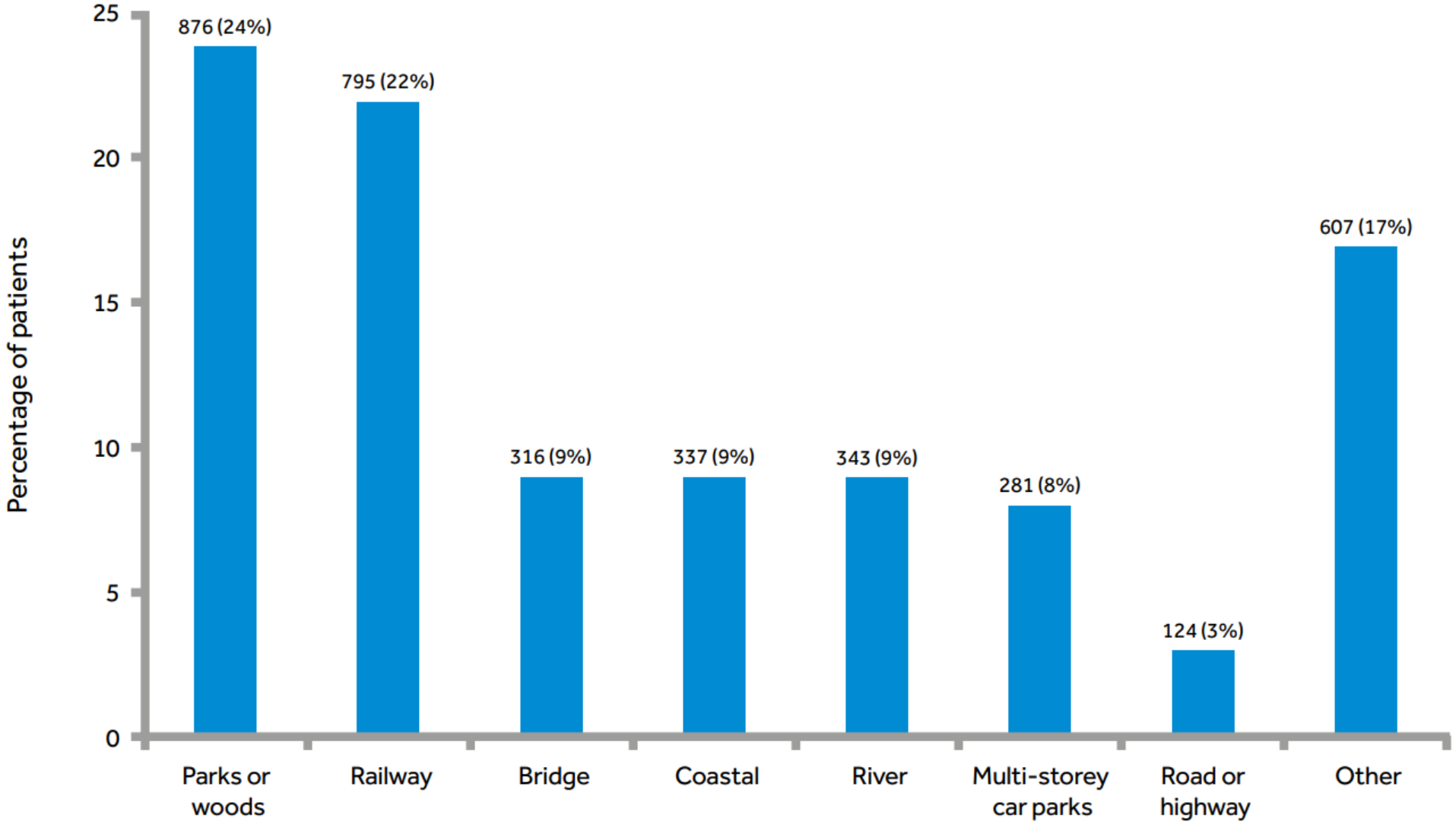
Source: NCISH

Autism and ADHD, UK



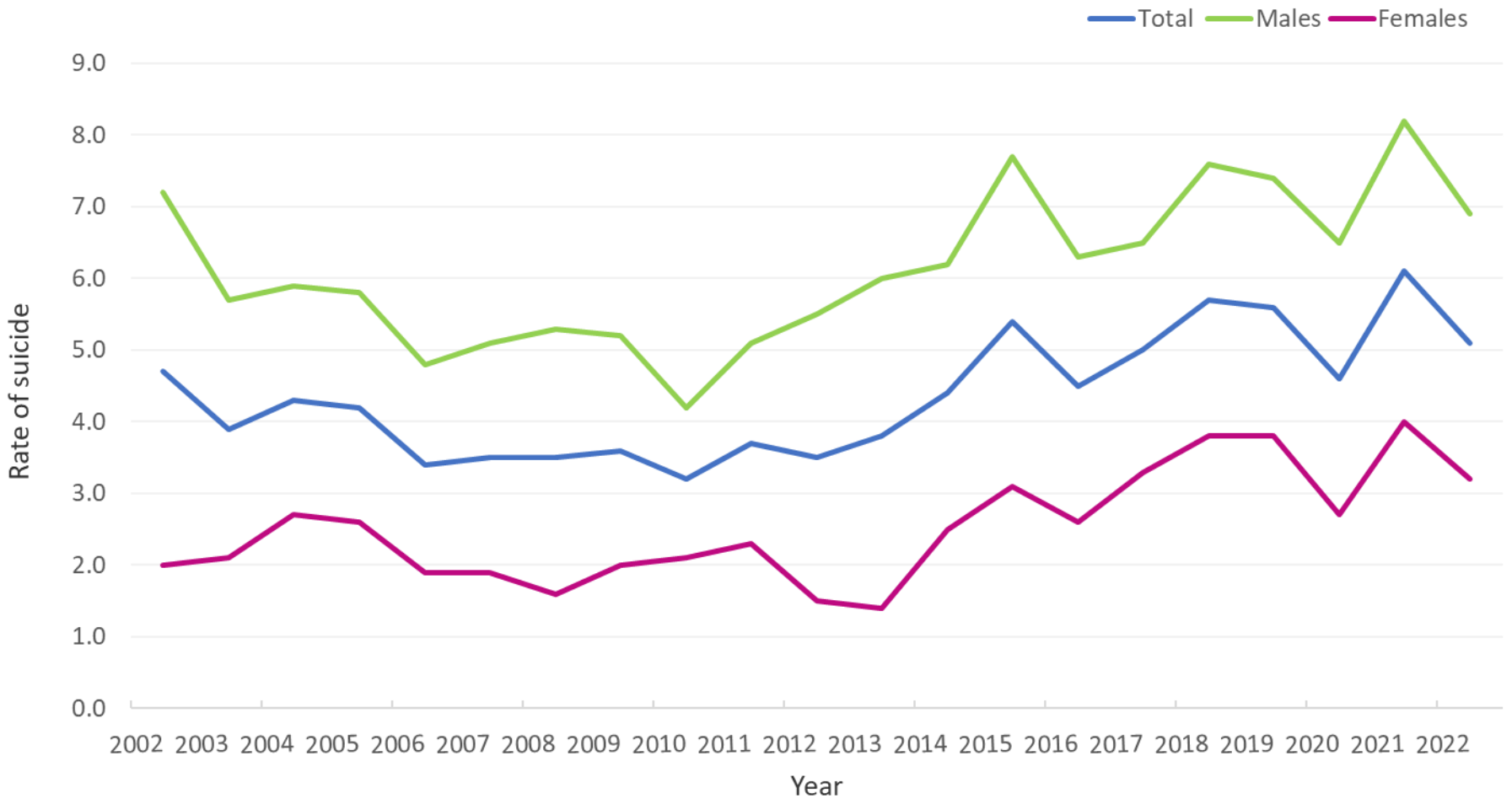
Source: NCISH

Suicide in a public location, UK



Source: NCISH

Suicide rates in 15-19 year olds



Rise over several years

Covid disruption 2020-2021

No overall change since 2018

Source: ONS Suicides in England: 2022 registrations

Common themes in young suicides: national study

Online risk 24%

Had been in care 8%

Family factors 23%

Isolation 21%

Abuse 11%

Physical health 30%

Bereavement 25%

Alc/drug use 42%

Bullying 19%

LGBT 5%

Academic pressures 32%

Source: NCISH

New measures in suicide prevention strategy

New offence of encouraging self-harm

Tighter affordability checks on problem gamblers

Personalised approach to clinical risk

Mental health support in schools

£10m to charities

New measures in suicide prevention strategy

Alert system for new suicide methods

New study of NHS staff suicide

New Govt policies assessed for mental health impact

National real-time suicide surveillance

Panel Discussion

Adele Owen

Greater Manchester Suicide Prevention & Bereavement Support Programme Manager

Louis Appleby

Director of NCISH, Professor of Psychiatry

Nav Kapur

Head of Suicide Research, Professor of Psychiatry and Population Health

Sue Wilgoss

Advisor for Suicide Prevention with Lived Experience

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National Suicide Prevention

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ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

UCL

Close

Tom Ayers

Director

National Collaborating Centre for Mental Health (NCCMH)