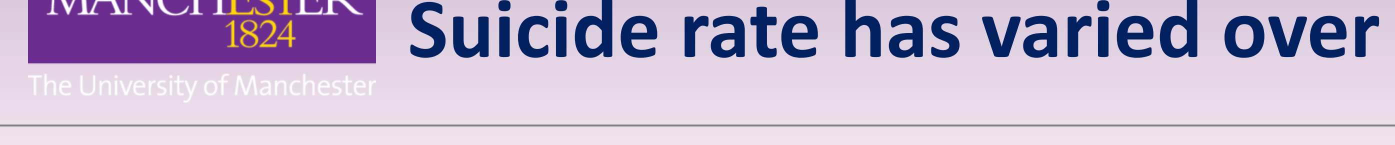
Suicide Prevention Learning Event

Professor Louis Appleby



Suicide rate has varied over time

18
16
14
12
10
8
6
4
2
0

Record low

2018 rise

Suicide rates falling

Post recession rise

Males
Females
Persons

2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018

Source: ONS, England

The University of Manchester

Change in the standard of proof

BMJ 2019;366:l4745 doi: 10.1136/bmj.l4745 (Published 29 July 2019) Page 1 of 2

EDITORIALS

New standard of proof for suicide at inquests in England and Wales

Suicide can now be concluded on "balance of probabilities"

Louis Appleby *professor of psychiatry*[1], Pauline Turnbull *project director*[1], Nav Kapur *professor of psychiatry and population health*[1,2], David Gunnell *professor of epidemiology*[3], Keith Hawton *professor of psychiatry*[4]

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The standard of proof has been **lowered** from **criminal** to **civil** standard

It was **beyond reasonable doubt** but now **balance of probabilities**

Percentage change in the number of suicides per quarter

Quarter	Percentage change
2017/Q1	-4.4
2017/Q2	-2.5
2017/Q3	2.5
2017/Q4	-6.4
2018/Q1	10.4
2018/Q2	12.1
2018/Q3	11.4
2018/Q4	17.2
2019/Q1	8.5
2019/Q2	1.4
2019/Q3	1.8

Source: ONS, 2019

Gender differences

Age-specific suicide rate, 2018, England

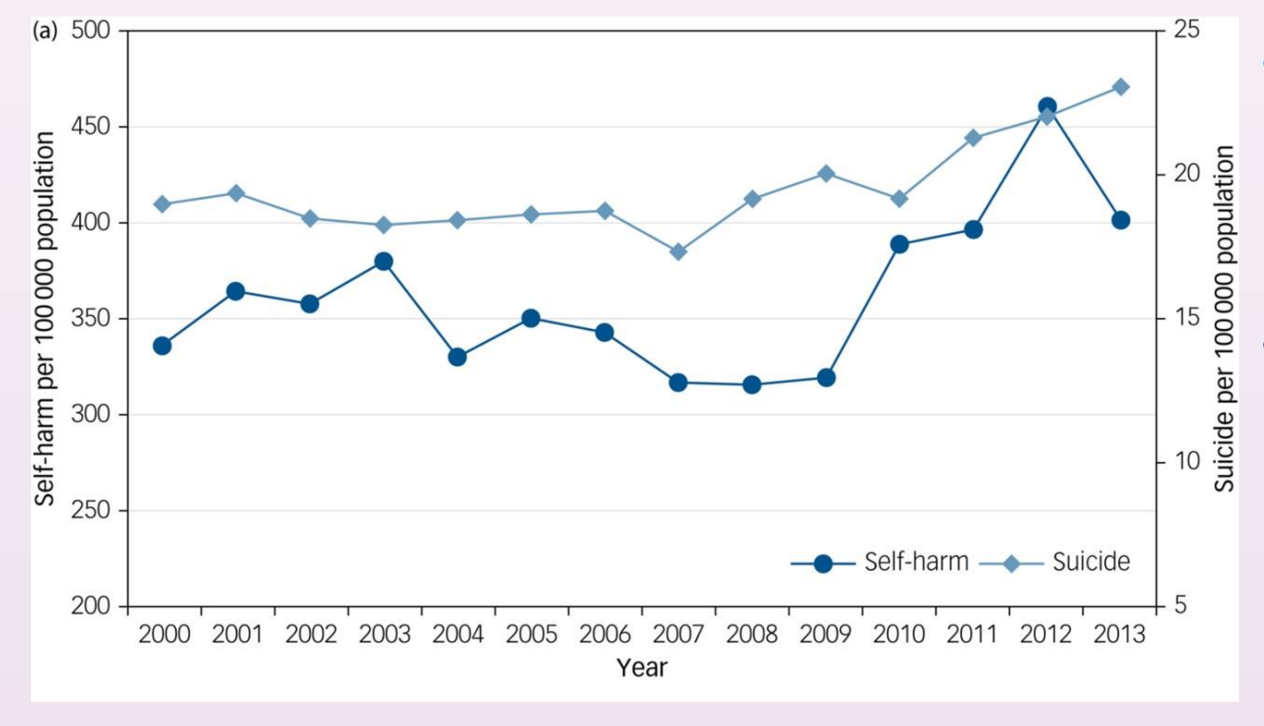
30.0
25.0
20.0
15.0
10.0
5.0
0.0

15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75-79 80-84 85-89

Males
Females

Source: ONS

Self-harm in male midlife



- **Rise** in **self-harm** linked to rise In **suicide**
- Self-harm rise linked to **economic** factors and **alcohol**

BJPsych
The British Journal of Psychiatry (2019)
Page 1 of 8. doi: 10.1192/bjp.2019.90

Suicide rates in 15-19 year olds, 2000-2018

10
9
8
7
6
5
4
3
2
1
0

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018

All persons
Males
Females

Source: ONS data for England

Rising self-harm rates

Prevalence of non-suicidal self-harm in men and boys (A) and women and girls (B), by age group

A

2000
2007
2014

Prevalence (%)

25
20
15
10
5
0

16–24 25–34 35–44 45–54 55–64 65–74

Age group (years)

B

16–24 25–34 35–44 45–54 55–64 65–74

Age group (years)

McManus S, Gunnell D, Cooper C, Bebbington PE, Howard LM, Brugha T, Jenkins R, Hassiotis A, Weich S, Appleby L. Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. The Lancet Psychiatry. 2019 Jun 4.

Rising self-harm rates

Reasons for non-suicidal self-harm among men and boys (A) and women and girls (B) aged 16–74 years

A

B

To cope with feelings

To change situation

Prevalence (%)

0 1 2 3 4 5 6 7 8

2000 2007 2014

Year

2000 2007 2014

Year

McManus S, Gunnell D, Cooper C, Bebbington PE, Howard LM, Brugha T, Jenkins R, Hassiotis A, Weich S, Appleby L. Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. The Lancet Psychiatry. 2019 Jun 4.

Suicide after self-harm

Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study

Galit Geulayov, Deborah Casey, Liz Bale, Fiona Brand, Caroline Clements, Bushra Farooq, Nav Kapur, Jennifer Ness, Keith Waters, Apostolos Tsiachristas, Keith Hawton

Summary

Background Self-harm is the strongest risk factor for subsequent suicide, but risk may vary. We compared the risk of suicide following hospital presentation for self-harm according to patient characteristics, method of self-harm, and variations in area-level socioeconomic deprivation, and estimated the incidence of suicide by time after hospital attendance.

Methods In this ongoing Multicentre Study of Self-harm in England, the study population consists of individuals aged at least 15 years who had attended the emergency department of five general hospitals in Oxford, Manchester, and Derby after non-fatal self-harm between Jan 1, 2000, and Dec 31, 2013. Information on method of self-harm was obtained through systematic monitoring in hospitals. Level of socioeconomic deprivation was based on the Index of Multiple Deprivation (IMD) characterising the area where patients lived, grouping them according to IMD quintiles. Mortality follow-up was up to Dec 31, 2015, resulting in up to 16 years of follow-up. We calculated incidence of suicide since first hospital presentation by follow-up period and estimated the association between individual factors (age, gender, method of self-harm, IMD, and number of non-fatal self-harm presentations to hospital) and suicide using mixed-effect models.

Findings Between Jan 1, 2000, and Dec 31, 2013, there were 92 177 presentations to the study hospitals by 51 108 individuals. 1325 patients involved in 1563 self-harm episodes were excluded from the study because they had missing information on gender, age, or mortality. The resulting study sample consisted of 90 614 hospital presentations by 49 783 individuals. By the end of follow-up on Dec 31, 2015, 703 patients had died by suicide. The overall incidence of suicide was 163·1 (95% CI 151·5–175·6) per 100 000 person-years, and 260·0 (237·4–284·8) per 100 000 person-years in men and 94·6 (83·3–107·4) per 100 000 person-years in women. The incidence of suicide was highest in the year following discharge from hospital (511·1 [451·7–578·2] per 100 000 person-years), particularly in the first month (1787·1 [1423·0–2244·4] per 100 000 person-years). Based on all presentations to hospital, men were three times more likely than women to die by suicide after self-harm (OR 3·36 [95% CI 2·77–4·08], p<0·0001). Age was positively related to suicide risk in both genders, with a 3% increase in risk for every one-year increase in age at hospital presentation (OR 1·03 [1·03–1·04], p<0·0001). Relative to hospital presentations after self-poisoning alone, presentations involving both self-injury and self-poisoning were associated with higher suicide risk (adjusted OR 2·06 [95% CI 1·42–2·99], p<0·0001), as were presentations after self-injury alone (adjusted OR 1·36 [1·09–1·70], p=0·007). Similarly, relative to self-harm by self-poisoning alone, attempted hanging or asphyxiation (adjusted OR 2·70 [1·53–4·78], p=0·001) and traffic-related acts of self-injury (adjusted OR 2·99 [1·17–7·65], p=0·022) were associated with greater risk of suicide. Self-cutting combined with self-poisoning was also associated with increased suicide risk (adjusted OR 1·36, [1·08–1·71], p=0·01). Compared with those patients living in the most deprived areas, those who lived in the least deprived areas (first national IMD quintile) had a greater risk of dying by suicide (adjusted OR 1·76 [1·32–2·34], p<0·0001) after adjusting for gender, age, previous self-harm, and psychiatric treatment, as did those living in the second least deprived areas (adjusted OR 1·64 [1·20–2·25], p=0·002).

Interpretation Patients attending hospital for self-harm are at high risk of suicide, especially immediately after hospital attendance. Certain patient characteristics and methods of self-harm, together with living in areas of low socioeconomic deprivation, can increase patients' subsequent suicide risk. However, while specific risk factors can be usefully integrated into the assessment process, individual factors have poor utility in predicting suicide, so the needs and risks of all patients should be assessed to develop appropriate aftercare plan, including early follow-up.

Funding UK Department of Health and Social Care.

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D Total study population in the first 12 months

2500
2000
1500
1000
500
0

1
2
3
4–6
7–12

Time since hospital discharge (months)

Source: Geulayov, G., Casey, D., et al. (2019). Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study. *The Lancet Psychiatry*, *6*(12), 1021-1030.

Suicide after self-harm in young people

Mortality in children and adolescents following presentation to hospital after non-fatal self-harm in the Multicentre Study of Self-harm: a prospective observational cohort study

Keith Hawton, Liz Bale, Fiona Brand, Ellen Townsend, Jennifer Ness, Keith Waters, Caroline Clements, Nav Kapur, Galit Geulayov

Summary

Background Self-harm and suicide in children and adolescents are growing problems, and self-harm is associated with a significant risk of subsequent death, particularly suicide. Long-term follow-up studies are necessary to examine the extent and nature of this association.

Methods For this prospective observational cohort study, we used data from the Multicentre Study of Self-harm in England for all individuals aged 10–18 years who presented to the emergency department of five study hospitals in Oxford, Manchester, and Derby after non-fatal self-harm between Jan 1, 2000, and Dec 31, 2013. Deaths were identified through the Office for National Statistics via linkage with data from NHS Digital up until Dec 31, 2015. The key outcomes were mortality after presentation to hospital for self-harm, categorised into suicide, accidental deaths, and death by other causes. We calculated incidence of suicide since first hospital presentation for self-harm and used Cox proportional hazard models to estimate the associations between risk factors (sex, age, previous self-harm) and suicide.

Findings Between Jan 1, 2000, and Dec 31, 2013, 9303 individuals aged 10–18 years presented to the study hospitals. 130 individuals were excluded because they could not be traced on the national mortality register or had missing data on sex or age, thus the resulting study sample consisted of 9173 individuals who had 13 175 presentations for self-harm. By the end of the follow-up on Dec 31, 2015, 124 (1%) of 9173 individuals had died. 55 (44%) of 124 deaths were suicides, 27 (22%) accidental, and 42 (34%) due to other causes. Of the 9173 individuals who presented for self-harm, 55 (0·6%) died by suicide. Most suicide deaths involved self-injury (45 [82%] of 55 deaths). Switching of method between self-harm and suicide was common, especially from self-poisoning to hanging or asphyxiation. The 12-month incidence of suicide in this cohort was more than 30 times higher than the expected rate in the general population of individuals aged 10–18 years in England (standardised mortality ratio 31·0, 95% CI 15·5–61·9). 42 (76%) of 55 suicides occurred after age 18 years and the annual incidence remained similar during more than 10 years of follow-up. Increased suicide risk was associated with male sex (adjusted hazard ratio 2·50, 95% CI 1·46–4·26), being an older adolescent at presentation to hospital for self-harm (1·82, 0·93–3·54), use of self-injury for self-harm (2·11, 1·17–3·81; especially hanging or asphyxiation [4·90, 1·47–16·39]), and repeated self-harm (1·87, 1·10–3·20). Accidental poisoning deaths were especially frequent among males compared with females (odds ratio 6·81, 95% CI 2·09–22·15).

Interpretation Children and adolescents who self-harm have a considerable risk of future suicide, especially males, older adolescents, and those who repeated self-harm. Risk might persist over several years. Switching of method from self-harm to suicide was common, usually from self-poisoning to self-injury (especially hanging or asphyxiation). Self-harm is also associated with risk of death from accidental poisoning, particularly involving drugs of abuse, especially in young males.

Funding UK Department of Health and Social Care.

C

Survival (%)

100, 90, 80, 70, 60, 50, 40, 30, 20, 10, 0

0, 5, 10, 15

Time since first presentation for self-harm (years)

100, 99, 98, 97

$P_{log\text{-}rank}=0{\cdot}0023$

Self-poisoning alone

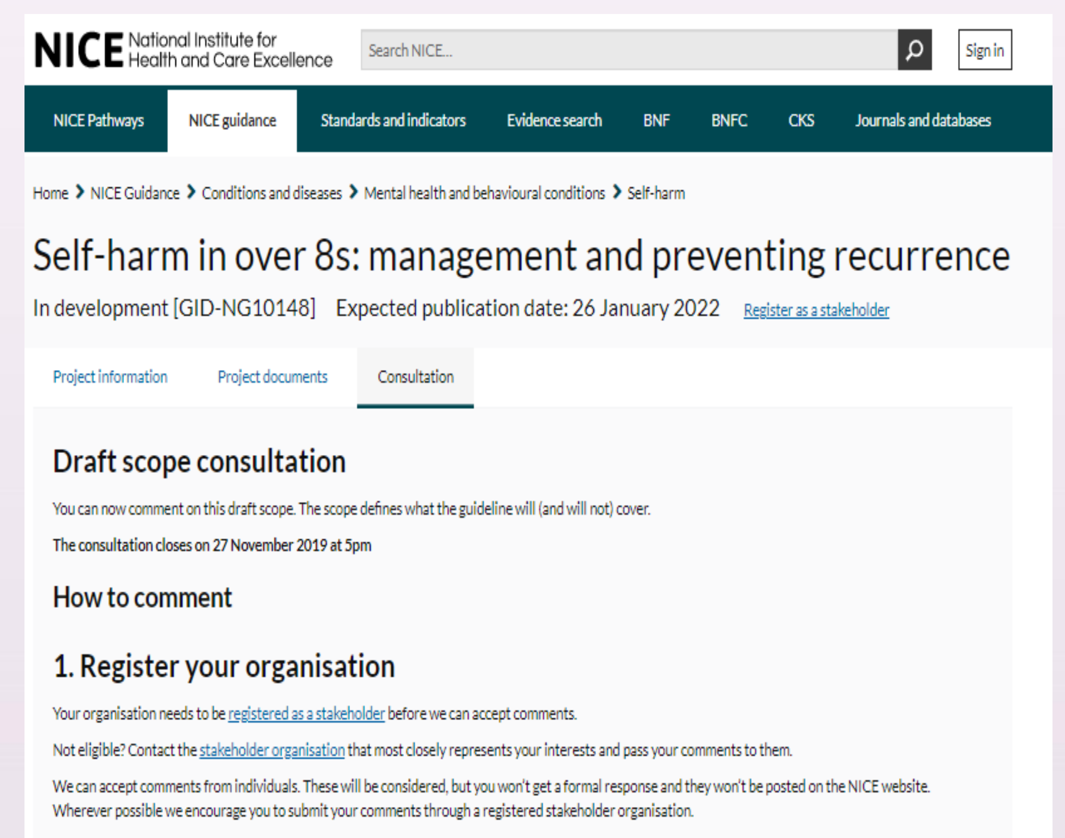
Self-injury alone

Self-poisoning and self-injury

Figure 2: Kaplan-Meier curves for death by suicide, by sex (A), age at first presentation for self-harm (B), and by method of self-harm at first presentation (C)

Source: Hawton, Keith et al. "Mortality in Children and Adolescents Following Presentation to Hospital after Non-Fatal Self-Harm in the Multicentre Study of Self-Harm: a Prospective Observational Cohort Study." *The Lancet Child & Adolescent Health.*

NICE self-harm guidelines – Draft scope



NICE National Institute for Health and Care Excellence

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Home > NICE Guidance > Conditions and diseases > Mental health and behavioural conditions > Self-harm

Self-harm in over 8s: management and preventing recurrence

In development [GID-NG10148] Expected publication date: 26 January 2022 Register as a stakeholder

Project information | Project documents | Consultation

Draft scope consultation

You can now comment on this draft scope. The scope defines what the guideline will (and will not) cover.

The consultation closes on 27 November 2019 at 5pm

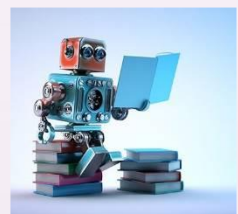
How to comment

1. Register your organisation

Your organisation needs to be registered as a stakeholder before we can accept comments.

Not eligible? Contact the stakeholder organisation that most closely represents your interests and pass your comments to them.

We can accept comments from individuals. These will be considered, but you won't get a formal response and they won't be posted on the NICE website. Wherever possible we encourage you to submit your comments through a registered stakeholder organisation.



Risk assessment/machine learning

Harm minimisation

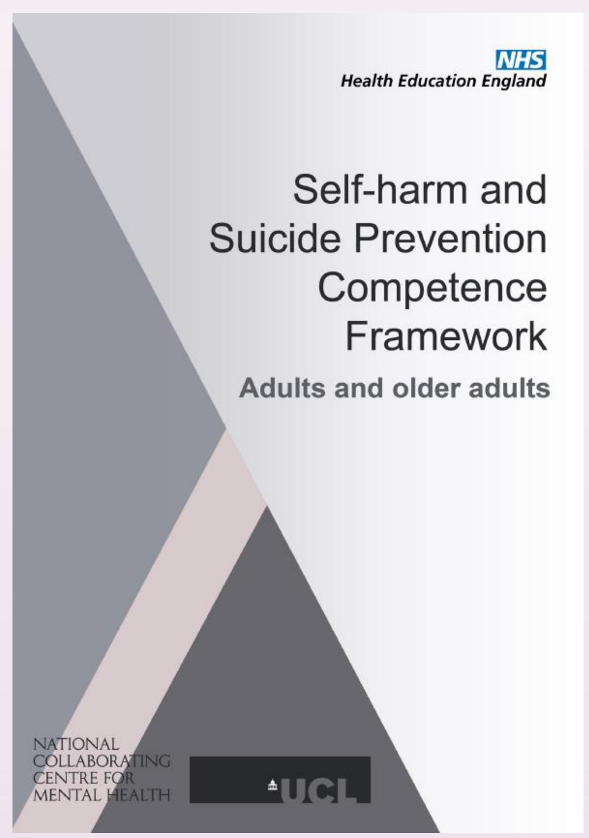
Assessment and interventions

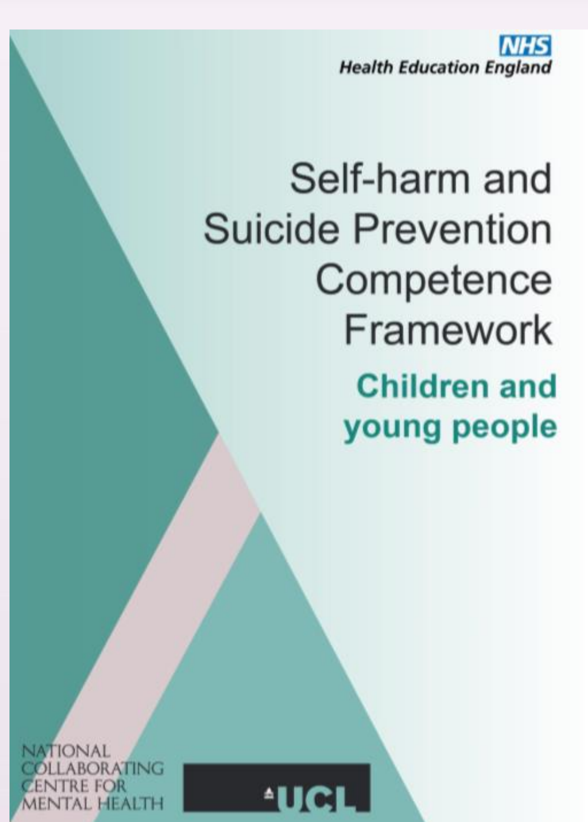
Guidelines

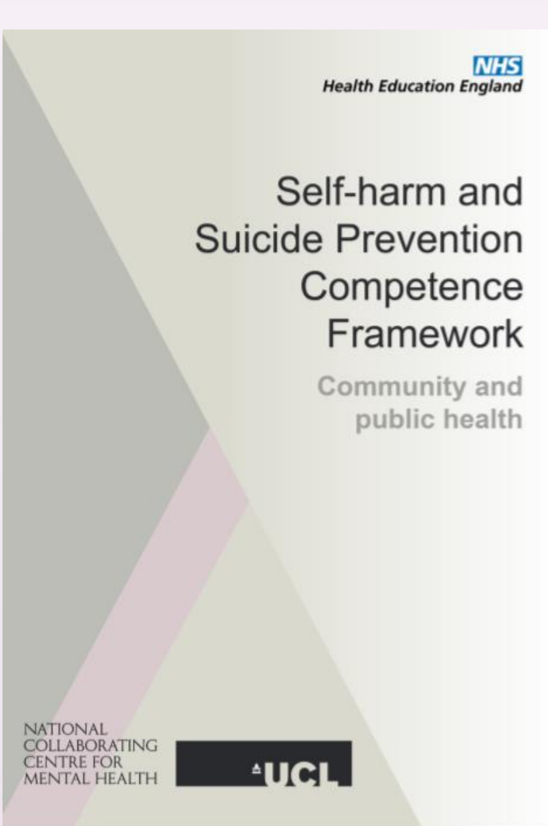
NICE quality standards for self-harm 2013

1 People are treated with compassion, respect and dignity
2 They receive an initial assessment of physical health, mental state, social circumstances and risk of suicide.
3 They receive a comprehensive psychosocial assessment
4 They receive the monitoring they need to keep them safe
5 They are cared for in a safe physical environment
6 Collaborative risk management plan are in place.
7 They have access to psychological interventions.
8 There is a transition plan when moving between services.

Competencies







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

In-patient suicide

Year	In-patient suicide	Hanging/strangulation on the ward
2007	122	20
2008	104	20
2009	100	28
2010	92	25
2011	101	23
2012	93	32
2013	96	24
2014	76	26
2015	89	28
2016	88	23
2017	73	19

Number of patients (y-axis); Year (x-axis)

40% ↓ 2007-2017

32% on ward

52% on agreed leave

16% off ward

England_SUICIDE (2007-2017)

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Suicide per week after discharge

Weeks between discharge and suicide (Week 1 = First week following discharge)	Number of patients
1	296
2	244
3	209
4	172
5	167
6	131
7	111
8	106
9	99
10	88
11	85
12	98
13	84

Highest risk on day 3

England_SUICIDE (2007-2017)

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‘10 ways’ to improve safety

10 ways to improve safety

- Safer wards
- Early follow-up on discharge
- No out-of-area admissions
- 24-hour crisis teams
- Family involvement in ‘learning lessons’
- Guidance on depression
- Personalised risk management
- Outreach teams
- Low staff turnover
- Reducing alcohol and drug misuse

Source: NCISH

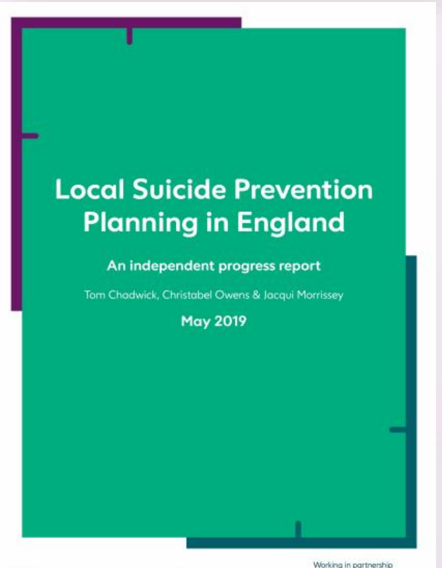
The New Programme

STPs with higher suicide rates

Local authority suicide prevention plans

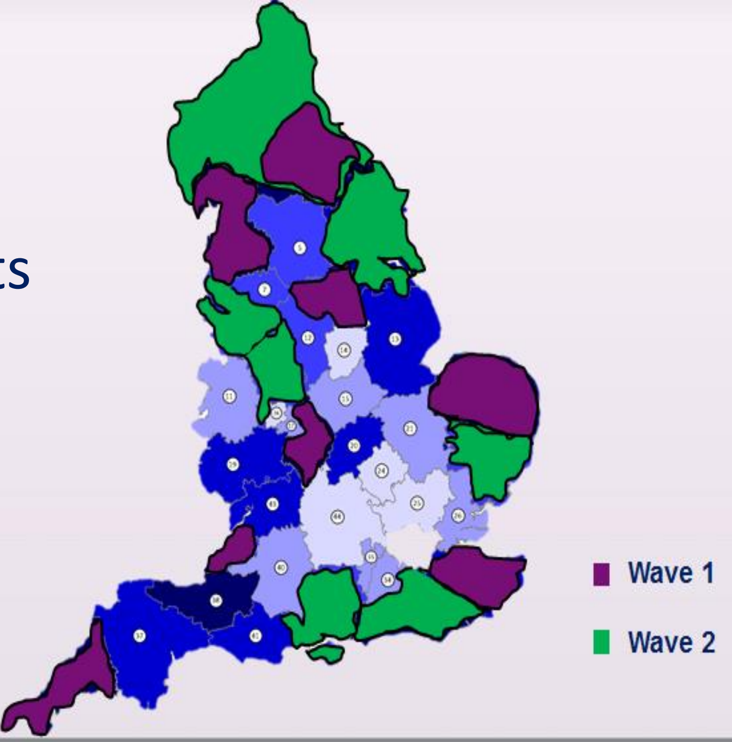
Zero suicide plans for in-patient care

STP mental health plans



3 priority areas:

- Mental health patients
- Self-harm
- Middle-aged men



Suicide rates in NHS areas (2015-2017)

Suicide rates

- < 8.0
- 8.0 - 9.0
- 9.1 - 10.0
- 10.1 - 11.0
- > 11.0

Variation by geography:

Highest rates in north & south-west

Lowest rates in London & south-central areas

High rates also in **rural** & **coastal areas**

ENGLAND_SUICIDE (2007-2017)

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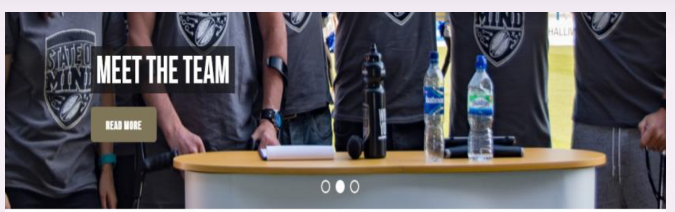
Men, sport and pubs



STATE OF MIND SPORT IS A CHARITY THAT HARNESSES THE POWER OF SPORT TO PROMOTE POSITIVE MENTAL HEALTH AMONG OUR SPORTSMEN AND WOMEN, FANS AND WIDER COMMUNITIES, AND ULTIMATELY TO PREVENT SUICIDE.

WE RAISE AWARENESS OF THE ISSUES SURROUNDING MENTAL HEALTH AND WELL BEING AND DELIVER EDUCATION ON THE SUBJECT TO ALL LEVELS OF SPORT, BUSINESS, EDUCATION AND COMMUNITY GROUPS.

WE SIGNPOST INDIVIDUALS TO WHERE THEY CAN RECEIVE CARE AND SUPPORT IN THEIR AREA.

FIRST ESTABLISHED IN UK SUPER LEAGUE IN 2011, STATE OF MIND SPORT IS NOW A MUCH-LOVED NATIONAL CHARITY AND INTERNATIONAL MOVEMENT DELIVERING ITS MESSAGE ACROSS RUGBY LEAGUE, RUGBY UNION, MULTIPLE OTHER SPORTS, AGE GROUPS AND TERRITORIES.

SUPPORT | DONATE | CONTACT

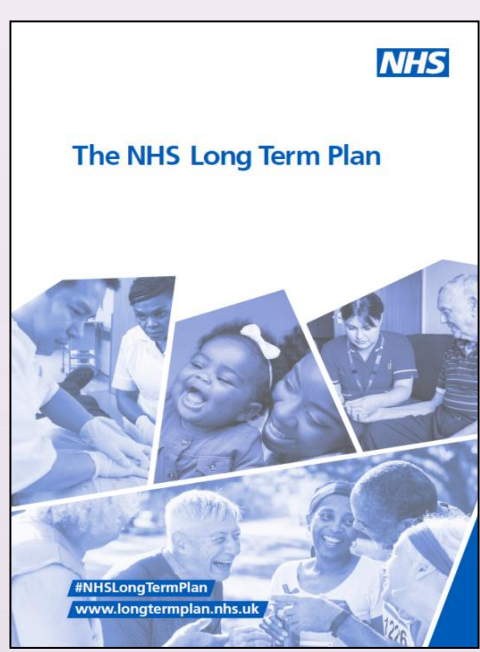
Get Set to GO

mind
for better mental health

Real Time Surveillance

2 purposes:

- **Early data;** accurate up to date data & ability to monitor patterns or trends
- **Bereavement support**



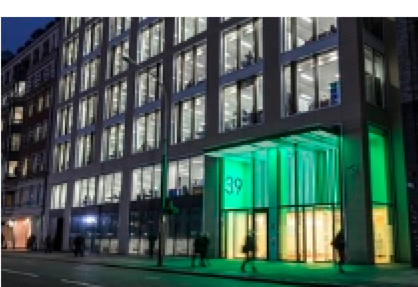
Announcement on bereavement support

News story

Suicide bereavement support to be made available across England

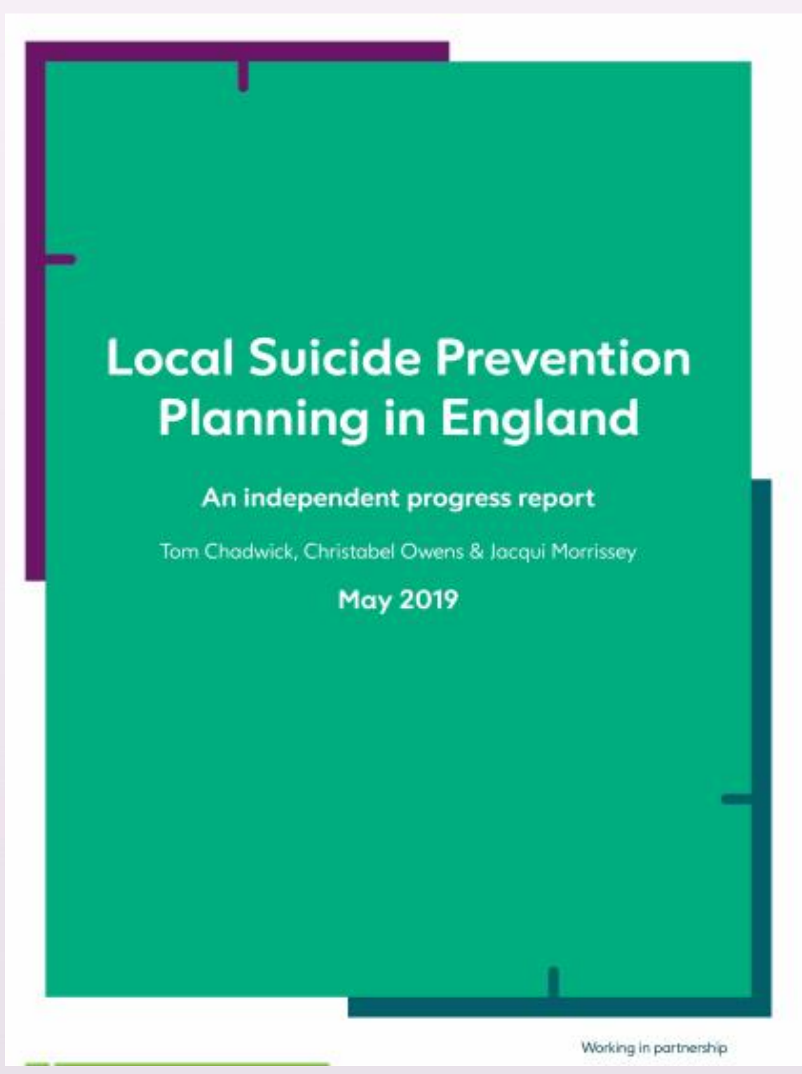
Personalised bereavement support will be available on the NHS in England to care for people after a relative or friend's suicide.

Published 27 October 2019
From: Department of Health and Social Care



People who have lost someone close to them due to suicide will benefit from

Local Suicide Prevention Planning in England



99% of LAs have established/developing a suicide prevention action plan

Plans covering 3 priorities:

97% reducing risk in **men**

92% prevention and response to **self-harm**

83% improving **acute mental health care**

Other plans:

97% bereavement support

92% improving mental health of children and young people