Emile Durkheim 1858-1917
Age-standardised suicide rates (2001-2016)

Source: ONS
Contact with NHS in year before suicide

- Around 1/3 have contact with mental health services
- Additional 1/3 have contact with primary care only
- Around 1/3 have no contact, mainly young & male

![Bar chart showing contact with NHS in year before suicide by age bands.](chart.png)
Collecting NCISH data

All potential cases nationally
(e.g. ONS, GRO (N. Ireland and Scotland), Homicide Index)

Contact with mental health services

Detailed data collection via questionnaire
Key findings: suicide
Patient suicides

Year


Number of patients

0 200 400 600 800 1,000 1,200 1,400 1,600

1,277 1,124 1,144 1,213 1,167 1,262 1,339 1,372 1,301 1,213 1,164

ENGLAND_SUICIDE (2005-2015)
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Patient suicide rates

- Falling rates but problem estimating patient numbers
- Changing clinical population

Year

<table>
<thead>
<tr>
<th>Rate per 100,000 MH service users</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td>2005</td>
<td>156.3</td>
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</table>

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Method of suicide
Patient suicide: main causes of death

- Hanging/strangulation: 5,909 (44%)
- Self-poisoning: 3,274 (24%)
- Gas inhalation: 317 (2%)
- Jumping/multiple injuries: 2,107 (16%)
- Other: 1,217 (9%)
- Drowning: 712 (5%)
Patient suicide method

- **Hanging**
  - Commonest method & rising over 10 years
  - Almost half died by hanging in 2015
  - Fall in self-poisoning

![Graph showing suicide method trends over 10 years](image-url)
Suicide in clinical settings
In-patient suicide

- Slower fall in recent years: 31% in 2005-10, 14% in 2010-15
- Average 89 deaths per year since 2011
Suicide under crisis teams (CRHT)

- 2x as many suicides under CRHT as in in-patients
- ⅓ under CRHT for <1 week
- ⅓ recently discharged from hospital
Suicide <3 months of hospital discharge

- Downward trend in England and Scotland
- In the UK, 23% fall in 2011-2015
Suicides per week after discharge, England

- Peak risk in first 2 weeks
- Link to short admission, care plan, life events

Source: NCI
Risk assessment at final contact

- Most viewed as low/no risk
- Long-term risk seen as higher

Source: NCI
Recent trends in patient suicide
Non-adherence or missed contact

- Downward trend despite rise in overall patient numbers
- 31% fall in non-adherence in 2010-2015
Mental health teams’ views: preventability

- Greater availability of psychiatric beds: 5%
- Better staff training in risk assessment: 12%
- Better communication between teams: 12%
- Use of MHA: 3%
- Closer supervision of patient: 25%
- Access to psychological treatment: 12%
- Access to drug services: 2%
- Access to alcohol services: 5%
- Availability of dual diagnosis services: 6%
- Improved adherence with drug treatment: 18%
- Closer contact with patient’s family: 16%
- Other factors: 14%

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Changing pattern of antecedents

- Self-harm
- Economic adversity
- Migration
- Suicide websites

Proportion seen at ED for self-harm in 3 months before suicide

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Patients with alcohol and drug misuse

- Alcohol and/or drug misuse – 54%
- Under either drug or alcohol services – 11%
How to improve safety
Do NCI recommendations improve safety?

- Removal of ligature points
- Assertive outreach
- 24-hour crisis team
- 7-day follow-up
- Non-compliance
- Dual diagnosis
- Criminal justice information sharing
- Multi-disciplinary review
- Training in suicide risk management

Source: Lancet, 2012

* = significant difference p<0.05
10 ways to improve safety

- Safer wards
- Dual diagnosis service
- Early follow-up on discharge
- No out-of-area admissions
- Low staff turnover
- 24 hour crisis teams
- Outreach teams
- Family involvement in 'learning lessons'
- Personalised risk management
- Guidance on depression
Outline

• Self-harm – the context

• Self-harm – what works?

• Primary care, men, and other population based approaches
Self-harm – the context
Self-harm

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

80%

20%
Iceberg model of suicidal behaviour

Boys

- Suicide Rate*: 16.5
- Hospital-treated self-harm*: 256.2
- Self-harm in the community*: 2,400

Girls

- Suicide Rate*: 2.7
- Hospital-treated self-harm*: 438.1
- Self-harm in the community*: 8,900

Ratio of suicide rate to rate of hospital-treated self-harm and to rate of self-harm in the community:

Boys: 1:16:146
Girls: 1:162:3,296
Percentage of population reporting self-harm

Source: NatCen 2016
Every year, hospitals in England deal with around 220,000 self-harm episodes by 150,000 people

Hawton et al 2007
Over 50% of children and young people who died by suicide had a history of self-harm.

30-50 times greater risk of suicide in the year after self-harm.
Life expectancy

Men

80+ years

Men who self-harm

40 years

Bergen et al 2012, Lancet
Temporal trends in annual age specific self harm incidence stratified by sex

Catharine Morgan et al. BMJ 2017;359:bmj.j4351
Variations in self-harm services

Cooper et al 2013
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.
What works?

Psychosocial assessment may reduce the risk of repeat self-harm by 40%

Kapur et al 2013
Psychosocial assessment
Observational data on 35,938 individuals presenting with self-harm to 3 centres in England, comparing repetition in those receiving vs not receiving specialist assessment (adjusted for baseline characteristics)

Kapur et al 2013
What helps?

The assessment itself

*The main thing was that [psychiatrist] did look as if he actually cared, that's it, and he wanted, he really wanted to help me, and so that was a very positive thing”* (P4)

Access to aftercare

*I'm hugely grateful that I've got the help, it's made a whole world of difference [yeah], I'm getting regular phonecalls, people are phoning me, keeping me informed, my care people are coming, I know that within the next couple of weeks, I will have the support I need”* (P10).

Hunter et al 2013
What helps?

Psychosocial assessment may reduce the risk of repeat self-harm by **40%**

Talking treatments as part of aftercare have an important role too (**NNT 33**)

Kapur et al 2013
Risk tools and scales to predict suicide after self-harm:

- Positive Predictive Value less than 5%
- So they are wrong 95% of the time
- And they miss suicide deaths in the large ‘low risk’ group

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<th>S</th>
<th>Sex</th>
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<tr>
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</tr>
<tr>
<td>S</td>
<td>Sickness</td>
</tr>
</tbody>
</table>
UK NICE Guidelines:

- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

- Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

- Risk assessment tools may be considered to help structure, prompt, or add detail to assessment.
So what should we do instead?

- Recognise that risk prediction is a fallacy
- Address patient needs
- Focus on the therapeutic aspects of the assessment
- Use clinical guidelines and make evidence based treatments available
- Individualised assessment and assessments which inform management
- Adopt population approaches to prevention – ‘something for everyone’
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.
**Clinicians**
- Better guideline adherence
- Improved knowledge and confidence
- Around a 10% improvement

**Patients**
- Little effect overall on change in suicidal ideation, future attempts, satisfaction
- A possible effect on patients with depression?

(De Beurs et al 2015)
Primary care, men, and other population based approaches
Patients who died by suicide 2002-2011: primary care consultation, treatment, and referral

2,384 patients who died by suicide

- Face-to-face GP consultation within 12 months of suicide
  - number = 1,504 (63%)

- Psychotropic drug treatment within 12 months of suicide
  - number = 1,148 (48%)

- Mental health referral within 12 months of suicide
  - number = 188 (8%)
Patients who died by suicide 2002-2011: primary care consultation, treatment, and referral

2,384 patients who died by suicide

Face-to-face GP consultation within 12 months of suicide  
number= 1,504 (63%)

Psychotropic drug treatment within 12 months of suicide  
number= 1,148 (48%)

Mental health referral within 12 months of suicide  
number= 188 (8%)
Suicide risk & number of GP consultations in previous 12 months

- Suicide linked to frequent GP consultation
- 12-fold increase with attendance x 2 per month
- Risk also high in non-attenders
Age-specific suicide rate, 2016

Source: ONS
Men and high suicide risk

- Dangerous methods
- Poor help-seeking
- More risk factors (drugs, alcohol, socioeconomic)
- Psychological characteristics
Other population based approaches

Preventing suicide in community and custodial settings

In development [GID-PHG95]  Expected publication date: 18 September 2018  Register as a stakeholder

Preventing suicide in community and custodial settings:
Draft guidance consultation
Other population based approaches

Restricting access to means
Support for bereaved families

Media
Schools
Working with your STP to improve safety

- Incorporating evidence into your Quality Improvement Plans
- Individual visits
- Focussing on your local concerns
- Providing bespoke data for your STP, working with you to understand your data
Website:
http://www.manchester.ac.uk/nci

Like us on Facebook
https://www.facebook.com/pages/Centre-for-Mental-Health-and-Safety

Follow us on Twitter
https://twitter.com/NCISH_UK