Report for Kent Health & Wellbeing Board on Mental Wellbeing in Kent

There are two *key* public health indicators in the National Public Health Outcomes Framework. These are 'Suicide' and a 'potential placeholder' for 'social isolation'. The 'placeholder' indicator means that it is not clear yet how this indicator will be measured or monitored. Therefore for the purposes of this report only progress on Suicide will be discussed.

However, Appendix 3 shows that on the new national measure of subjective well-being, the Kent population appears to be happier but more anxious then the England population.

1. Introduction: Suicide – Why this is an important issue for Kent

Suicide is a major public health issue and is a devastating event for families and communities. Suicide rates in Kent are slightly lower compared to England. In Kent 121 people (aged over 15) committed suicide or died by undetermined causes[i] in 2012. Suicide is responsible for almost 1% of all deaths in Kent and is the highest cause of death in people aged 25-44 years old and one of the three leading causes of death in young people under 25. The Clinical Commissioning Group (CCG) with the highest suicide rates in Kent is South Coast Kent CCG.

A new national suicide strategy was published in 2012 with a stronger emphasis on public mental health and supporting families than previous strategies. This supports the National strategy for Mental Health "No Health without Mental Health" which outlines a holistic approach to improving population mental wellbeing. Suicide is often used as a 'proxy indicator' for public mental wellbeing and can indicate poor access to mental health services.

In Kent – there is a 'Kent and Medway Suicide Prevention Strategy' and this strategy runs up to 2015 but due to key policy changes is now due for refresh.

This report will outline key facts and figures about suicide in Kent and provide an update on what the current strategy has achieved and where to go next.

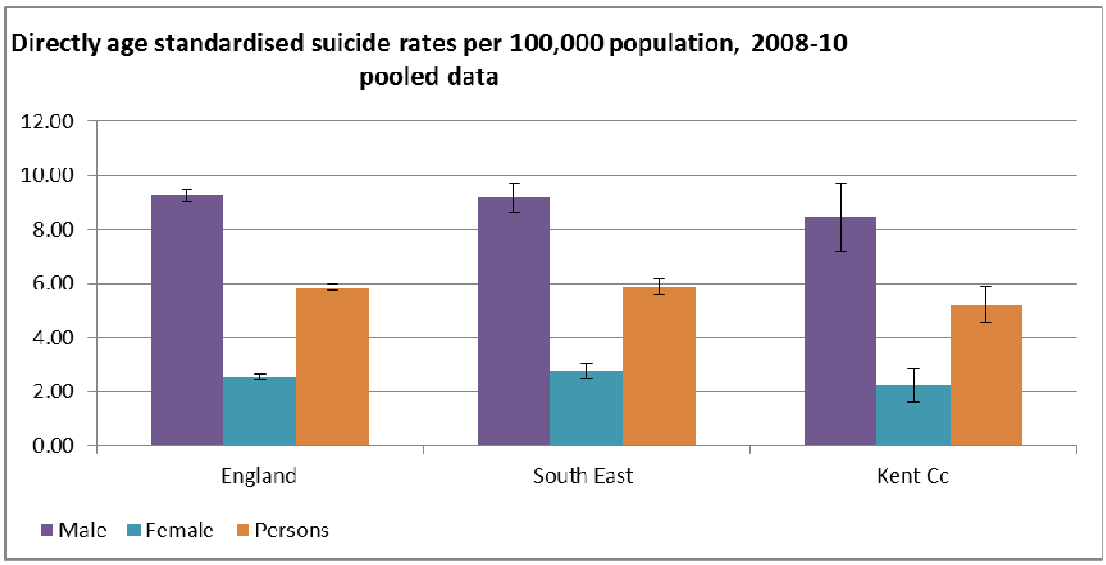
1.1 Suicide Rates in Kent

In Kent the Suicide rate for men is 8.43 per 100,000 people, for women, 2.24 per 100,000 people and for combined population 5.24 per 100,000 people for 2008-10 (Figure 1).

It is commonly acknowledged in the field of suicide research that official statistics underestimate the 'true' number and rate of suicide. The main reason for this is the misclassification of deaths i.e. the cause of death is coded as something other than suicide. An example of this may be where a coroner cannot establish whether there was intent by the individual to kill him/herself and the cause of death may be recorded as one of 'undetermined intent' or 'accidental'. This may occur in situations where the death involved a road traffic accident or where there is long term illness. It could also be

difficult to determine whether there was intent to die in situations of self-harm leading to suicide. This is why the actual number of suicides is usually higher than the reported numbers.

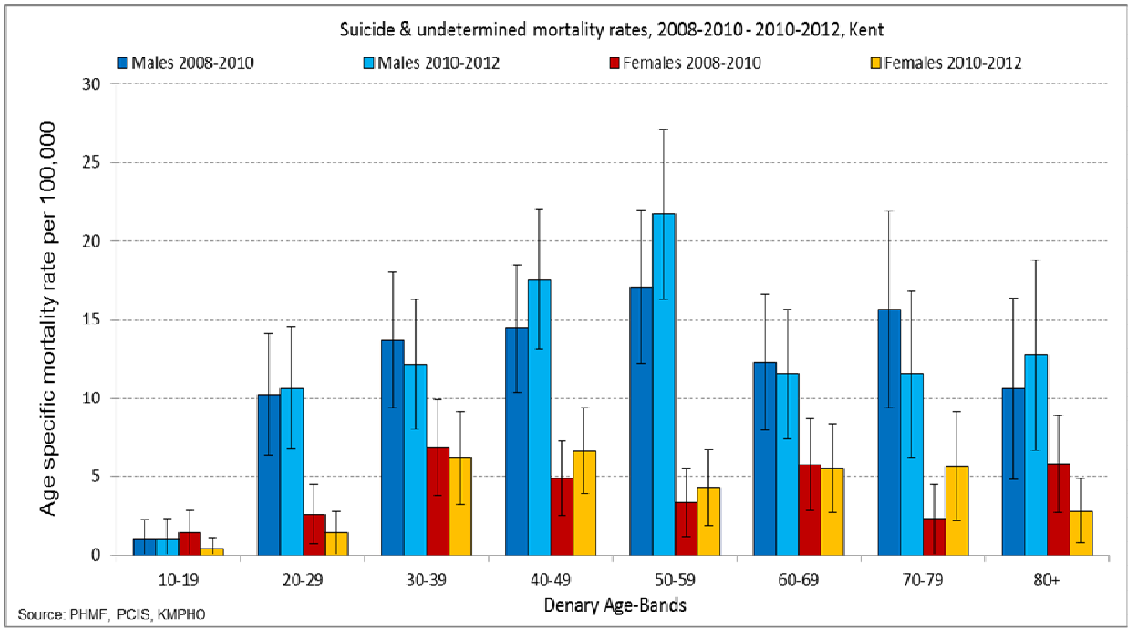
Figure 1



2. Who is at Risk of Suicide in Kent?

Most suicides in Kent are committed by white men aged between 30 and 60 (figure 2). This is similar to the national pattern. Based on national data approximately 30 per cent of people committing suicide have been in contact with mental health services. It is likely that the majority - between 65 and 75 per cent - have *not* been in contact with mental health services. This is why preventing suicide needs to involve people from a wide range of agencies and not just mental health services.

Figure 2



There are five main groups of people who are most at risk from committing suicide.

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups (doctors, nurses, veterinary workers, farmers and agricultural workers - probably because they have ready access to the means of suicide and know how to use them).

The Kent and Medway Suicide Prevention Action Plan for 2010-13 target these high risk groups.

There are also nine key groups identified in the National Suicide Prevention Strategy as needing tailored and targeted approaches to public mental wellbeing in order to reduce their suicide risk.

The Nine Key Groups are:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

The Kent Strategy and Action Plan will be reviewing these interventions in the next 12 months.

2.1 Self Harm or 'Para Suicide'

The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population. (Self-poisoning and self-injury in adults, Clinical Medicine, 2002)

People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past. (National Collaborating Centre For Mental Health). People who self-harm repeatedly are at a higher and persistent risk of suicide and even death. (Owens et al, 2002: Hawton et al, 2003).

In contrast to the trends in completed suicides, the incidence of self-harm has risen in the UK over the past 20 yrs and is a worrying feature of our society. Recent audits have highlighted that self-harm is high among young women.

In 2011 Public Health in West Kent conducted an audit of self-harm cases in A&E departments. Applying National Prevalence rates suggested that in 2007 an estimated 30,414 people in West Kent had a history of self-harm. The audit took place from 1st November 2011 to 31st January 2012 and found 126 cases of deliberate self-harm in that period. Of the cases audited, 62% were women and

38% men while 37% of all cases were aged between 16 and 25yrs and 72% of the cases aged 16- 25 yr. were young women.

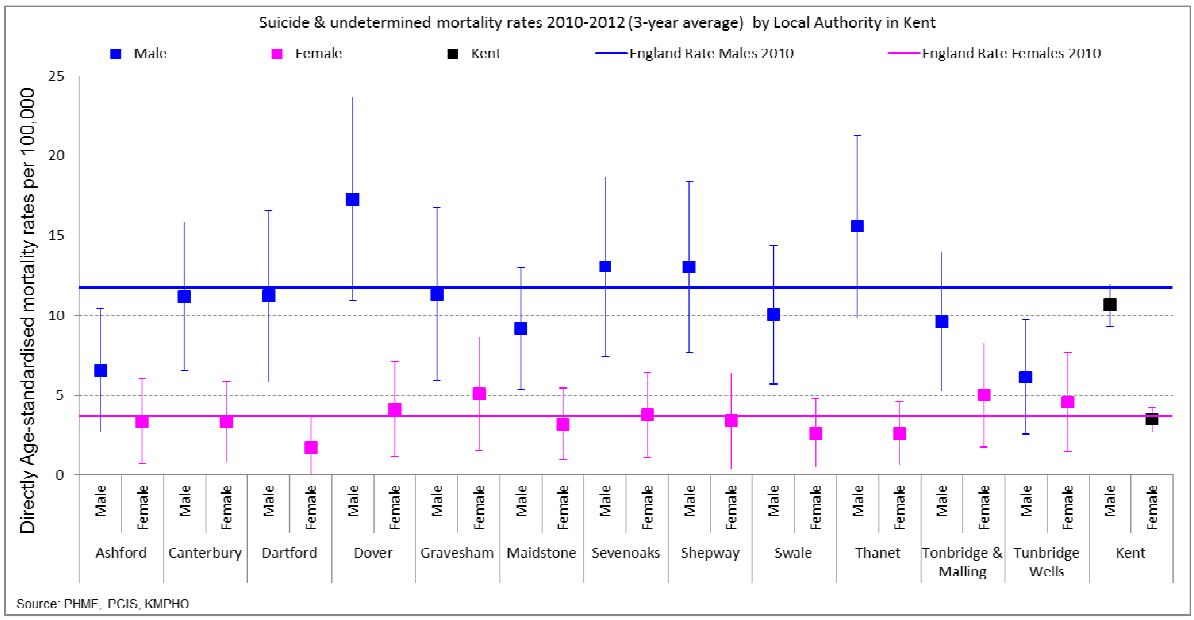
3. How do people commit suicide in Kent?

The majority of deaths due to suicide are a result of hanging. Men usually use this method. The next most used method is falling from a high point or throwing self onto rail tracks or traffic. Amongst women the most used method is poisoning (pills or other substances), however more recent reports from national data shows that women are using more aggressive methods of suicide.

4. Where are the 'hot spots' in Kent for Suicides?

Due to relatively small numbers of people committing suicides in each Kent district (see Appendix 1) the hot spot areas can fluctuate year on year. The highest number of people committing suicide in 2012 was from Dover District, where there were 17 deaths. When converted into rates (so that population size is accounted for) it is Dover and Thanet that are the hot spots for men and Gravesham, Tonbridge & Malling and Tunbridge Wells for women (Figure 3) as their rates are above that of the England average.

Figure 3



4. What are we doing about this? Review of Kent and Medway Suicide Prevention Plan 2010-2015.

There are five core actions outlined in the Kent & Medway Suicide Prevention Plan. These are:

- Reducing risk in high risk groups
- Promoting the wellbeing in the wider population
- Reducing the availability and lethality of methods of suicide
- Improving reporting of suicides in the media
- Monitoring of suicides and statistics

Appendix 2 provides a brief report on progress and achievements to the Plan.

The plan has been largely successfully implemented. It must be noted that there were no NHS PCT funds allocated for public mental health in the last 5 years and therefore actions taken to implement the plan were largely bending mainstream funding to become more responsive to the public's mental health.

The Mental Well Being Programme in Kent from 2010 to present consisted of:

- The Live it well website
- A Local signposting pilot at primary care in Thanet
- Implementation and audit of psychological therapies
- Improving data and needs assessment
- Improving veteran and military wellbeing via a Kent wide counselling programme and network
- Investment and delivery of a young healthy minds programme to enable wider reach for CAMHS (Child mental health services)
- Time to Change campaign (anti Stigma)
- Investing in Health Trainers for offenders in probation services
- Working with Library services to provide books for well being
- Mental Well Being Impact Assessment in West Kent

4.1 New Investment into Public Mental Well Being by Public Health KCC

An evidenced based 10 point Plan for Well Being is in progress in order to tackle Adult Mental Well Being in Kent from 2013 to 2015 and has been progressed in the Public Health 100 day plan. This Mental Well Being Plan will be delivered in partnership with directorates across KCC and will benefit Health and Well Being Partners.

The 10 Point Plan is as follows:

i. Large Scale **Campaigns** using social marketing and working with other councils in the south east. **Signposting:** The Live it Well website will be improved and marketed to the whole population and publicised widely. (with FSC)
ii. **Workplace Health :**Across all directorates including Training
iii. **Primary Care:** GP practices will have workers who will link patients with common mental illness to community programmes and wellbeing services. (with FSC)
iv. **Community Development and Engagement**: Men will be targeted by using an innovative social marketed community engagement programme called SHEDs. This will also target ex-military. It is a peer support and outdoor activity programme that benefits the whole community. Also working with KCC Dementia friendly towns – community innovation funds will be strengthened. (With Customer and Communities & FSC)
v. **Asset Mapping:** There are many wellbeing programmes that are not funded by KCC or NHS that can be publicised and used to improve wellbeing. This programme will find them and map their economic and social impact to enhance and provide value for the public and commissioners. (With BSS Policy): Pilot areas Dover and Swale.
vi. **Mental Health Inequalities:** Conduct large scale mental wellbeing impact assessments (which is an internationally recognised community participation and action planning

methodology) to improve outcomes for people in targeted populations. (with Districts and CCGs and Voluntary Sector)

vii. **Training:** roll out Mental Health First Aid Training (suicide awareness) systematically across Kent

viii. **Improve Health of People with Mental Health Problems:** Health Trainers for people in community mental health services

ix. **Community Resilience Building** via **Healthy Living Centres:** Working with Libraries and Pharmacies to turn the community into a wellbeing friendly environment (with Customer and Communities & CCGs)

x. **Audit and Evaluation:** Continue to provide high quality data and evaluation on performance e.g. suicide and self-harm audit and psychological therapy access audit.

Report Author

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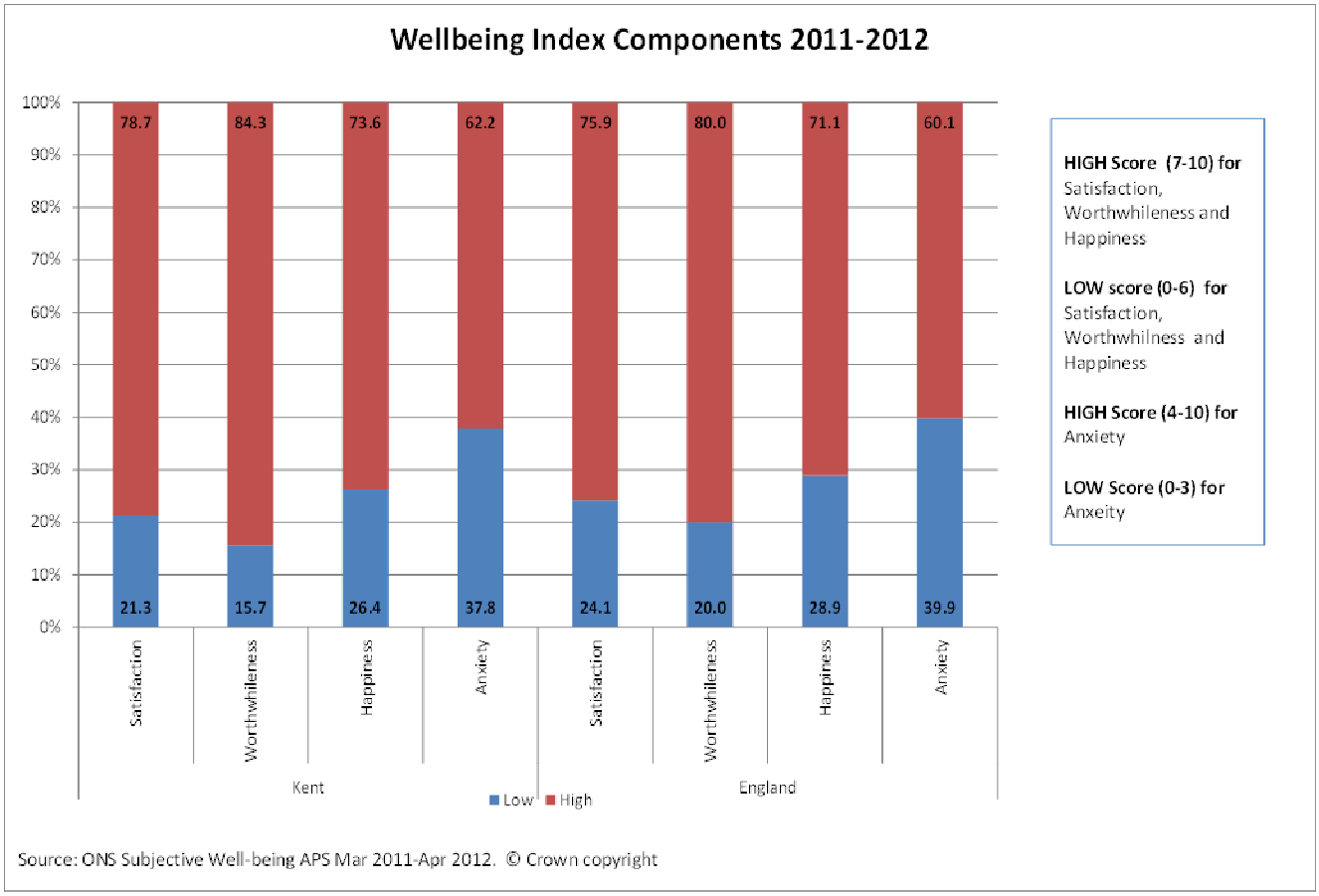
Appendix C

Appendix 1

Kent Well Being Index: Compared to England Average.

Kent scores on the new subjective wellbeing scale (measured by the Office of National Statistics) show that people in Kent are more satisfied, feel more worthwhile and more happy then the average England population, however- Kent scores indicated the population are more anxious then the England population.



Source: ONS Subjective Well-being APS Mar 2011-Apr 2012. © Crown copyright

Appendix C

Appendix 2

1.1Number of deaths from suicide and undetermined causes by district

Local Authority	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Ashford	13	9	*	11	7	9	*	6	7	7	*
Canterbury	12	12	14	14	13	10	9	14	10	10	10
Dartford	10	*	9	8	7	7	*	9	*	9	6
Dover	6	11	17	15	6	14	10	12	9	12	17
Gravesham	8	15	12	7	7	12	6	7	8	9	8
Maidstone	14	13	12	14	13	8	11	15	7	9	15
Sevenoaks	9	8	12	*	10	9	*	9	7	9	15
Shepway	11	17	*	13	8	8	*	9	10	12	8
Swale	*	9	17	9	14	10	9	15	11	6	10
Thanet	9	15	14	8	12	17	11	13	8	17	14
Tonbridge & Malling	6	8	6	8	7	11	7	14	11	9	9
Tunbridge Wells	14	14	7	14	10	11	14	9	7	7	7

1.2 Number of deaths from suicide and undetermined causes by CCG

Clinical Commissioning Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Grand Total
NHS Ashford CCG	13	9	3	11	7	9	4	6	7	7	5	81
NHS Canterbury CCG	12	16	16	16	16	17	10	20	13	13	15	164
NHS DGS CCG	22	28	27	16	18	22	8	21	15	23	22	222
NHS Medway CCG	23	12	20	21	23	22	14	19	14	13	20	201
NHS SKC CCG	17	26	20	27	13	20	12	19	18	24	22	218
NHS Swale CCG	4	7	16	8	12	5	8	11	9	3	8	91
NHS Thanet CCG	9	15	15	8	12	17	11	13	8	17	14	139
NHS West Kent CCG	39	35	31	39	36	36	35	42	30	29	38	390
Grand Total	**139**	**148**	**148**	**146**	**137**	**148**	**102**	**151**	**114**	**129**	**144**	**1506**

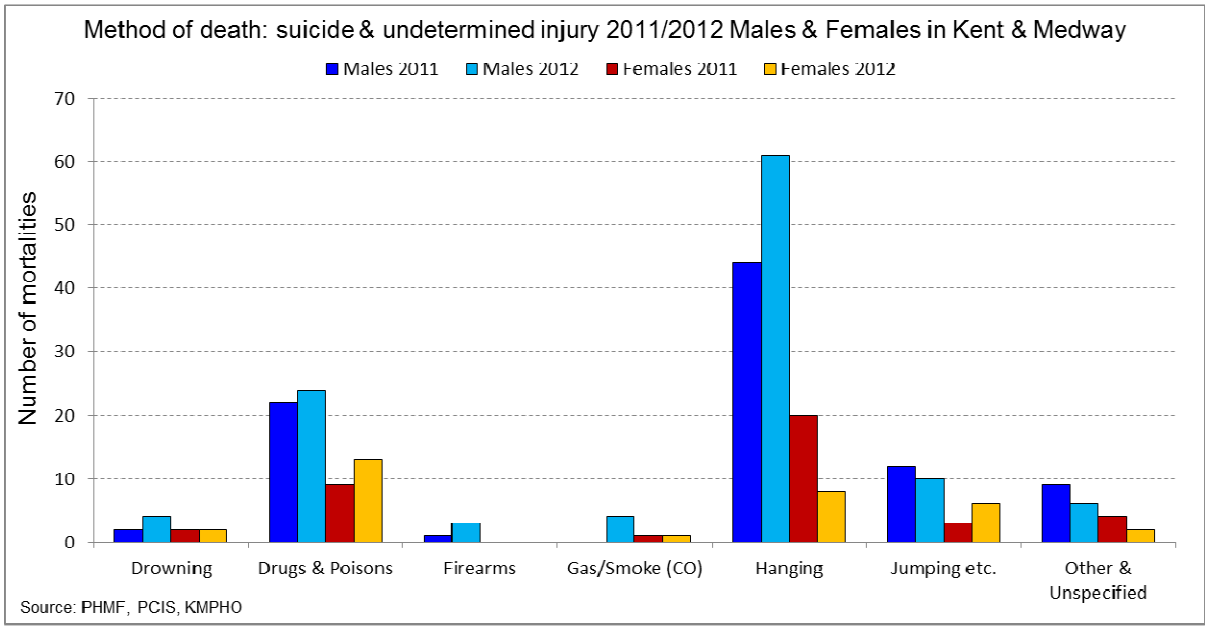
Year	Drowning	Drugs & Poisons	Firearms	Gas/Smoke (CO)	Hanging	Jumping etc.	Other & Unspecified	Grand Total
2002	5	14		1	8	5	2	**35**
2003	2	9			15	1	3	**30**
2004	3	15			6	3	4	**31**
2005	3	20		1	14	3	7	**48**
2006	2	13		1	10	1	6	**33**
2007	2	16		1	8	4	3	**34**
2008	4	10		1	11	1	2	**29**
2009	6	12			12	3	6	**39**
2010	1	10		1	13	3	3	**31**
2011	2	9		1	20	3	4	**39**
2012	2	13		1	8	6	2	**32**
Grand Total	**32**	**141**		**8**	**125**	**33**	**42**	**381**

1.3 Main method of suicide 2002-2012 in Kent and Medway females

1.4 Main method of suicide 2002-2012 in Kent and Medway males

Year	Drowning	Drugs & Poisons	Firearms	Gas/Smoke (CO)	Hanging	Jumping etc.	Other & Unspecified	Grand Total
2002	6	30	4	2	40	9	13	**104**
2003	4	22	3	1	66	11	11	**118**
2004	4	27	4	1	57	11	13	**117**
2005	4	25	2		53	7	7	**98**
2006	3	23	6	5	47	15	5	**104**
2007	9	32	1		49	9	14	**114**
2008	3	14	2		44	3	7	**73**
2009	6	25	3	2	54	12	10	**112**
2010	3	15	1		48	8	8	**83**
2011	2	22	1		44	12	9	**90**
2012	4	24	3	4	61	10	6	**112**
Grand Total	**48**	**259**	**30**	**15**	**563**	**107**	**103**	**1125**

1.5


Method of death: suicide & undetermined injury 2011/2012 Males & Females in Kent & Medway
Males 2011
Males 2012
Females 2011
Females 2012
Number of mortalities
70
60
50
40
30
20
10
0
Drowning
Drugs & Poisons
Firearms
Gas/Smoke (CO)
Hanging
Jumping etc.
Other & Unspecified
Source: PHMF, PCIS, KMPHO

Appendix 3

Summary of the Suicide Prevention Implementation Plan 2010-15

Priority	Actions taken/population affected	Status /activities
1. Reducing risk in high risk groups	High risk groups include: • those with mental illness • those who self-harm • offenders • older people • unemployed • those abusing substances	• Appropriate suicide prevention plan in place in KMPT. • Mandatory training of staff in suicide prevention and risk assessment continues • KCA and KDAAT are now part of the Steering Group • Ligature audits completed & recommendations implemented in KMPT. • Self-harm audit in A & Es carried out in East & West Kent & findings widely disseminated including in all councils. • Recommendations made to extend Liaison Psychiatric service in West Kent to 12 midnight every day like in East Kent • Some/most GPs need development to quickly identify patients at risk of suicide & training is being sourced • Mental Health services for prisoners now appropriately funded. • Training was carried out by programme manager for carers in West Kent in Feb 2013. Carers, especially carers looking after older people are targeted in next wave of mental health 1st AID training this month.
2. Promoting wellbeing in the wider population	• Those in financial difficulties • Those bereaved through suicides • Those misusing substances.	• Publication of articles in local papers • Radio interviews • Community sign posting now available through several avenues like One Stop shop, voluntary organisations, Liveitwell.org.uk etc. • KMPT supporting better access to information for those bereaved by suicide • KDAAT actively participating in the steering group should lead to better joint working between services

		• Having an equitable use of IAPT services
3. Reducing availability & lethality of methods	• Those deliberately dying by bridges & train stations • Those taking an overdose of prescribed drugs	• Hot spots have been identified including Ashford Bridge & Whitstable train station using data shared by Police • Samaritans have put posters & signage in place on the Whitstable line. http://www.thisiskent.co.uk/Woman-hit-train-suicide-spot/story-13688307-detail/story.html#axzz2XzSEb6mp • On-going discussions with KCC Major Capital Project unit re Ashford Bridge signage
4. Improving reporting of suicides in media	The media (including internet sites) could influence the decision of some population groups, such as young people to take their own lives through copycat action	Reporting monitored on an on-going basis through cuttings of press reporting and TV programmes
5. Monitoring of suicide statistics	Police, KMPT & other agencies sharing information collected with group.	• There is regular local monitoring of suicide trends in Kent and Medway • Baseline information has also been obtained on the trend of self-harming behaviour • Coroners have agreed to give regular updates to the KMPHO

[i] Undetermined causes are a category of coroner verdict that is counted along with Suicide by the ONS and is regarded as 'probable suicide'.