Suicide Prevention Needs Assessment

Kent

September 2018

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Version Control

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1. Executive Summary

1.1 Introduction

- Every suicide is a tragedy. The impact is devastating for the friends and family of the individual who died, as well as the wider community.
- Suicide prevention is a public health priority both nationally and locally, with a role for a wide range of statutory and community organisations.
- The current Kent and Medway Suicide Prevention Strategy runs from 2015 to 2020.
- The Kent and Medway STP was awarded £667,000 for additional suicide prevention programmes during 2018/19.

1.2 Key Findings

- Kent's suicide rate is higher than the national average, particularly amongst men.
- Men are at greater risk of dying by suicide than women, and middle-aged men are at the highest risk.
- Suicide rates vary across the different CCG areas within Kent and there is a socio-economic gradient to suicide with people in the most deprived communities experiencing higher rates of suicide.
- Other groups at higher risk include;
    - People in contact with secondary mental health services (particularly post discharge from inpatient settings)
    - People in contact with the criminal justice system
    - People experiencing social pressures (such as financial crisis or relationship breakdown)
    - People with co-existing substance misuse and mental health conditions
    - People with long term physical health conditions
    - Groups who experience discrimination or abuse (eg LGBT or some BME groups)
- The biggest single indicator of suicide risk is previous self-harm including previous suicide attempts
- In the year before someone dies by suicide, and in relation to their contact with the NHS;
    - Around 1/3 have contact with secondary mental health services
    - Around 1/3 have contact with primary care only
    - Around 1/3 have no contact with the NHS

1.3 Recommendations

1. Continue to implement the Kent and Medway 2015-2020 Suicide Prevention Strategy and Action Plan

2. Continue to implement and evaluate the 2018/19 STP Suicide Prevention funding programme
3. During 2019, develop a new Kent and Medway Suicide Prevention Strategy for 2020-2025

2. Introduction

2.1 Overview

Every suicide is a tragedy. The impact is devastating for the friends and family of the individual who died, as well as the wider community.

Suicide prevention is a public health priority both nationally and locally, with a role for a wide range of statutory and community organisations. Public Health England guidance suggests that public health teams within local authorities should take the lead bringing together local stakeholders to coordinate local action.

There is a national target to reduce suicide rates by 10% by March 2021. This target has also been adopted by the Kent and Medway STP locally.

2.2 Kent context

Kent County Council's Public Health team co-ordinates and leads the Kent and Medway Suicide Prevention Multi-Agency Steering Group which includes a variety of agencies, charities and individuals affected by suicide including;

- Medway Council
- KMPT
- Kent Police
- Network Rail
- Mind
- Samaritans
- Canterbury Christ Church University
- CCGs
- Survivors of Bereavement by Suicide

The Steering Group developed the 2015-2020 Kent and Medway Suicide Prevention Strategy and is responsible for implementing the associated Action Plan.

The Strategy includes the following six priorities;

i. Reduce the risk of suicide in key high-risk groups
ii. Tailor approaches to improve mental health and wellbeing in Kent and Medway
iii. Reduce access to the means of suicide
iv. Provide better information and support to those bereaved or affected by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring

In 2018, the Kent and Medway STP successfully bid for £667,000 from NHS England for additional suicide prevention programmes during 2018/19. Tim Woodhouse (Suicide Prevention Specialist within KCC) is responsible for implementing the agreed funded programme across the Kent and Medway STP footprint.

The funded programme has the following elements;

1) Extending the “Release the Pressure” social marketing campaign
2) Strengthening high risk points within secondary mental health services
3) Better support for those bereaved by suicide
4) At least 1000 people trained in suicide awareness and prevention
5) Innovation fund for grassroots projects
6) Suicide Safer Universities Programme
7) Workplace interventions in high risk industries
8) Qualitative research
9) Better identification and support for people in primary and local care settings

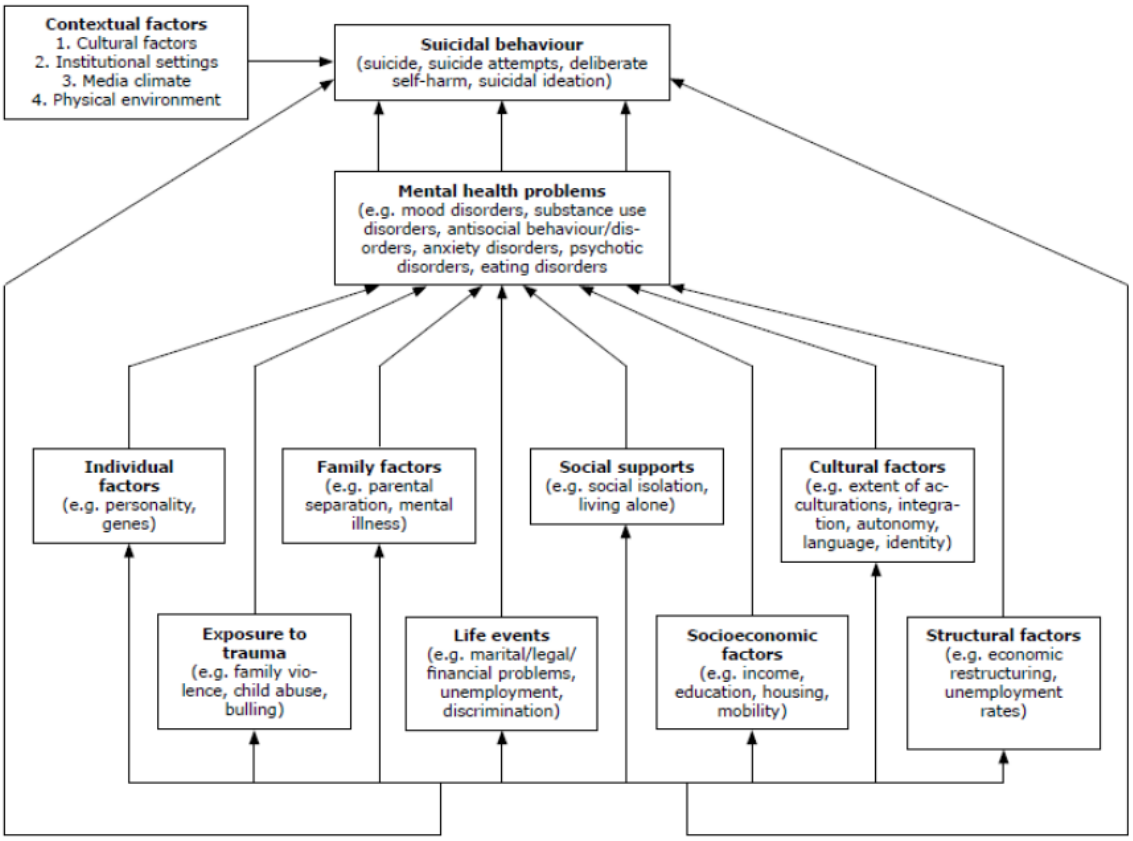
3. Key Findings

3.1 Who is at risk and why?

"There is no single reason why people take their own lives. Suicide is a complex and multi-faceted behaviour, resulting from a wide range of psychological, social, economic and cultural risk factors which interact and increase an individual's level of risk"[1]

This quote from a 2017 Samaritans report highlights the complexity of trying to identify who is at risk of suicide. In 2010, the Royal College of Psychiatrists further illustrated this complexity in their diagram of possible pathways to suicide (see Figure 1 below).[2]

Figure 1 Pathways to Suicide Behaviour



National and local research has shown that there are a number of factors which may mean that some individuals or groups are at higher risk of suicide than others. This needs assessment has been developed by analysing local and national data with the intention of identifying increased risk factors within the Kent population.

[1] Samaritans (2017) *Dying from inequality Socioeconomic disadvantage and suicidal behaviour* Available at http://bjp.rcpsych.org/content/early/2017/03/02/bjp.bp.116.189993

[2] Royal College of Psychiatrists (2010) College report CR158 *Self-harm, suicide and risk: helping people who self-harm* Available at http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf

3.2 Suicide statistics and data sources

Coroners are the only officials who can determine whether an individual death was a suicide or not. For a Coroner to reach a conclusion of suicide the intention of the person to end their own life must be beyond reasonable doubt.

However, to aid population level analysis of suicide behaviour, the Office of National Statistics recommend that suicide statistics include both Coroner confirmed suicides and deaths (of self-injury and poisoning) where the intent was undetermined.

To allow for accurate comparisons, suicide rates are reported as a rate per 100,000 (either as an annual or a three-year rolling average).

The statistics which make up this needs assessment come from a variety of sources. Each source will be identified when used, however the most frequent sources are as follows;

- Kent Public Health Observatory (using the Primary Care Mortality Database)
- Public Health England (using the FingerTips Online Tool)
- National Confidential Inquiry into Suicide and Homicide (based at the University of Manchester)

There is often a time delay (which could be months or even years) between the date of someone dying and the completion of a Coroner's inquest. To allow for the accurate inclusion of the most recent data, most of the statistics in this assessment are based on the date of suicide registration (rather than date of death).

During 2018 the KCC Public Health team is working with KCC's Coroner Service to analyse over 150 recent suicide verdicts. This will enable us to have a deeper understanding of what is happening in the lives of people who die by suicide in Kent in the months before they die. The results of this research will be added to future versions of this needs assessment.

3.3 Suicide numbers in Kent in recent years

The number of suicides registered by Coroners in Kent has fallen slightly over recent years. In 2017, the 123 registered suicides accounted for 0.8% of all Kent deaths.

Table 1 - Numbers of deaths from suicide and events of undetermined intent, 2010-2017 registrations, aged 15+ Kent residents, by gender

Area resident	Gender	2010	2011	2012	2013	2014	2015	2016	2017
Kent	Male	73	85	97	119	130	116	104	85
	Female	27	34	26	31	35	36	36	38
	Total	100	119	123	150	165	152	140	123

Source: Primary Care Mortality database, KPHO (JB); Medway Public Health

3.4 National comparisons

As Table 2 (below) shows, the suicide rate in Kent is higher than the national average, particularly for men.

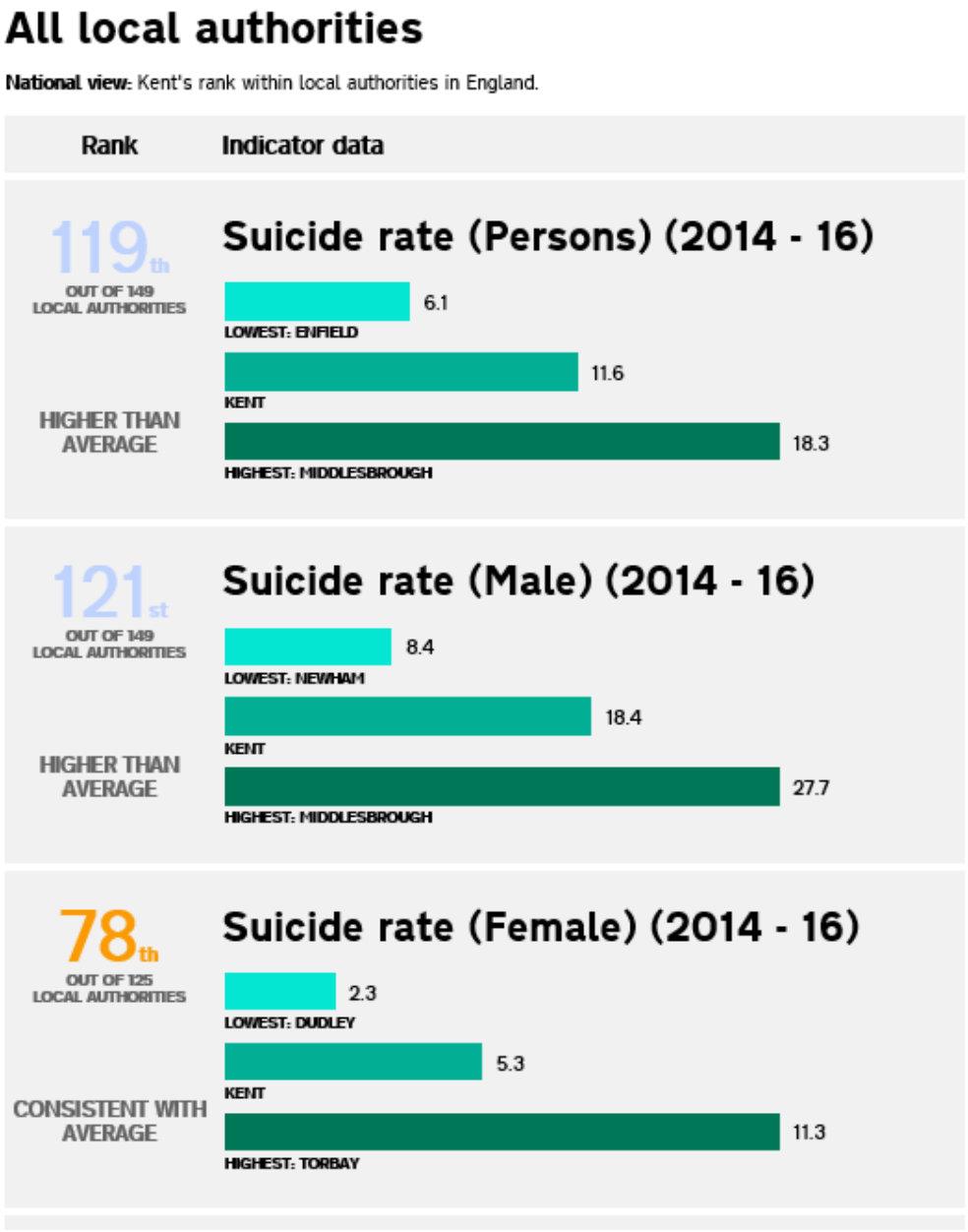
Table 2 – Age Standardised Suicide Rate per 100,000 (3 year average 2014-16) Kent compared to South East and England averages.

Indicator	Period	England	South East region	Kent
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2014 - 16	9.9	9.8	11.6
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2014 - 16	15.3	15.1	18.4
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2014 - 16	4.8	4.8	5.3

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data

Figure 2 below shows that Kent's male suicide rate ranks as the 121st highest out of 149 (top-tier and single-tier) local authorities.

Figure 2 – Suicide rate, local authority ranking



https://healthierlives.phe.org.uk/topic/suicide-prevention/area-details#are/E10000016/par/E92000001

3.5 CCG variation across Kent

There is wide variation in suicide rates across Kent (as shown in Table 5 below). Thanet, Swale and South Kent Coast CCG areas have the highest overall suicide rates. However West Kent CCG has the second highest female suicide rate.

Table 5 - Numbers of deaths and rates from suicide and undetermined causes, Kent CCGs, 2014 -2016 registrations, by gender, - residents aged 15+

Clinical commissioning group	Male		Female		Both sexes	
	Numbers	ASR / 100,000 [1]	Numbers	ASR / 100,000 [1]	Numbers	ASR / 100,000 [1]
NHS Ashford CCG	28	19.7	4	2.7	32	10.9
NHS Canterbury & Coastal CCG	40	16.4	12	4.7	52	10.5
NHS Dartford, Gravesham & Swanley CCG	63	20.7	8	2.4	71	11.4
NHS South Kent Coast CCG	54	21.1	14	5.5	68	13.0
NHS Swale CCG	33	24.0	9	6.7	42	15.5
NHS Thanet CCG	40	25.7	17	9.4	57	16.8
NHS West Kent	92	16.4	43	7.0	135	11.7

Source: PCMD, KPHO (JB)

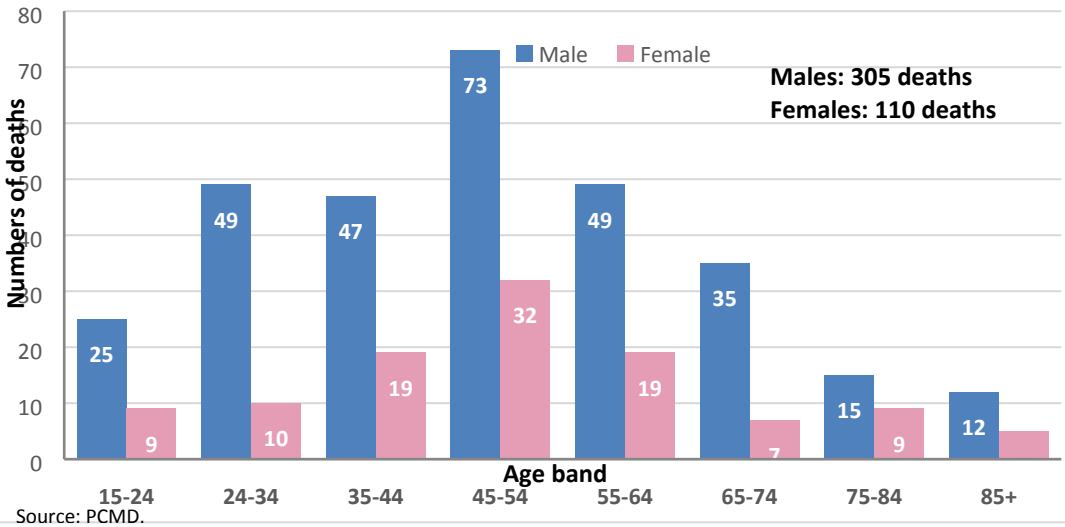
[1] Directly age-standardised mortality rate per 100,000 resident

3.6 High risk groups

3.6.1 Men

As Table 1 (above, page 8) shows over two-thirds (69%) of the individuals who died by suicide in Kent in 2017 were male. Chart 1 (below) shows that it is middle aged men who are at most risk.

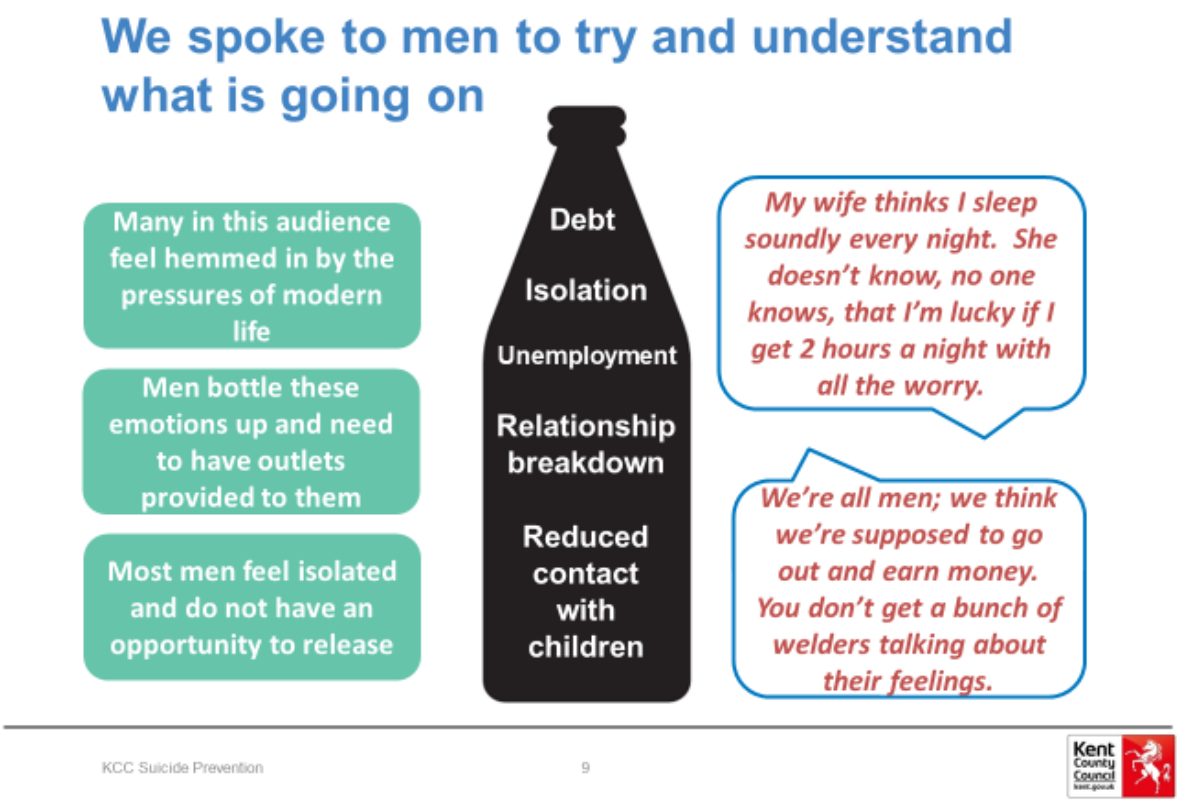
Chart 1 - Numbers of deaths from suicide and events of undetermined intent, 2015-17 by age band and gender



Source: PCMD.

Research in 2016 (in preparation of the Release the Pressure campaign) highlighted that many men felt depressed following life events such as relationship breakdown, money worries, isolation and were unable to express their feelings.

Slide 1 – Research with a focus group of men in 2016. KCC Public Health



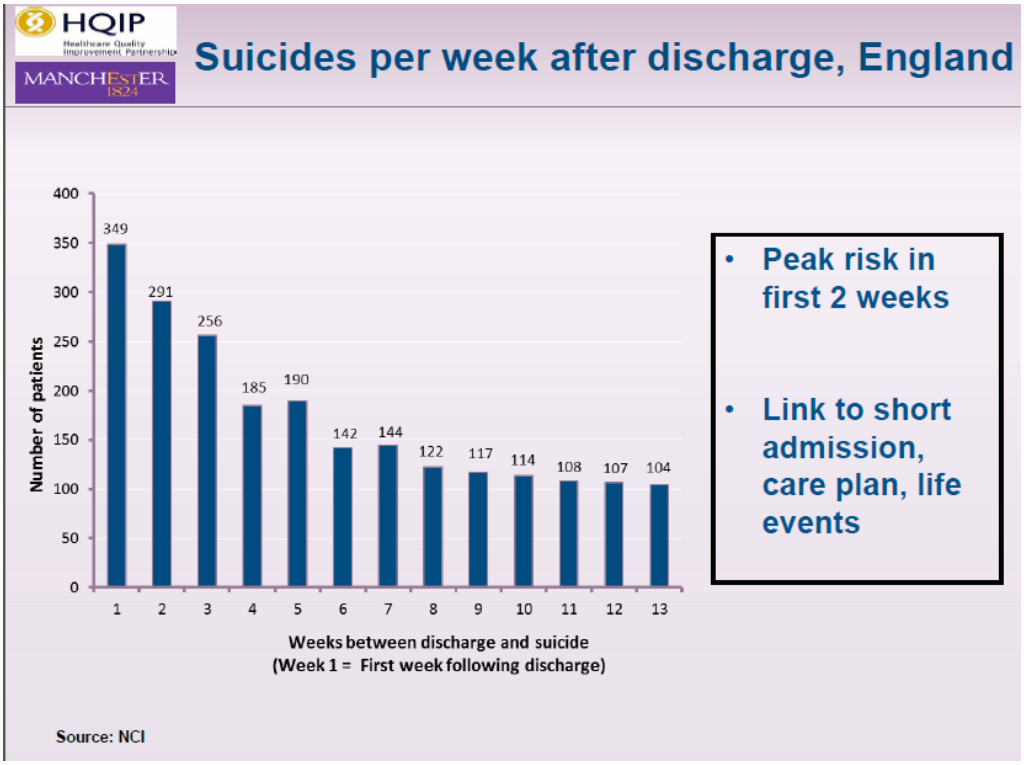
3.6.2 People in contact with mental health services

An analysis of the 2017 Kent suicide registrations has shown that 33% of people who died by suicide were known to KMPT (the local provider of secondary mental health services) in the year before they died. This corresponds well with national estimates (from the National Confidential Inquiry) that in the year before a death by suicide, and in relation to contact with the NHS;

- Around 1/3 have contact with secondary mental health services
- Around 1/3 have contact with primary care only
- Around 1/3 have no contact with the NHS

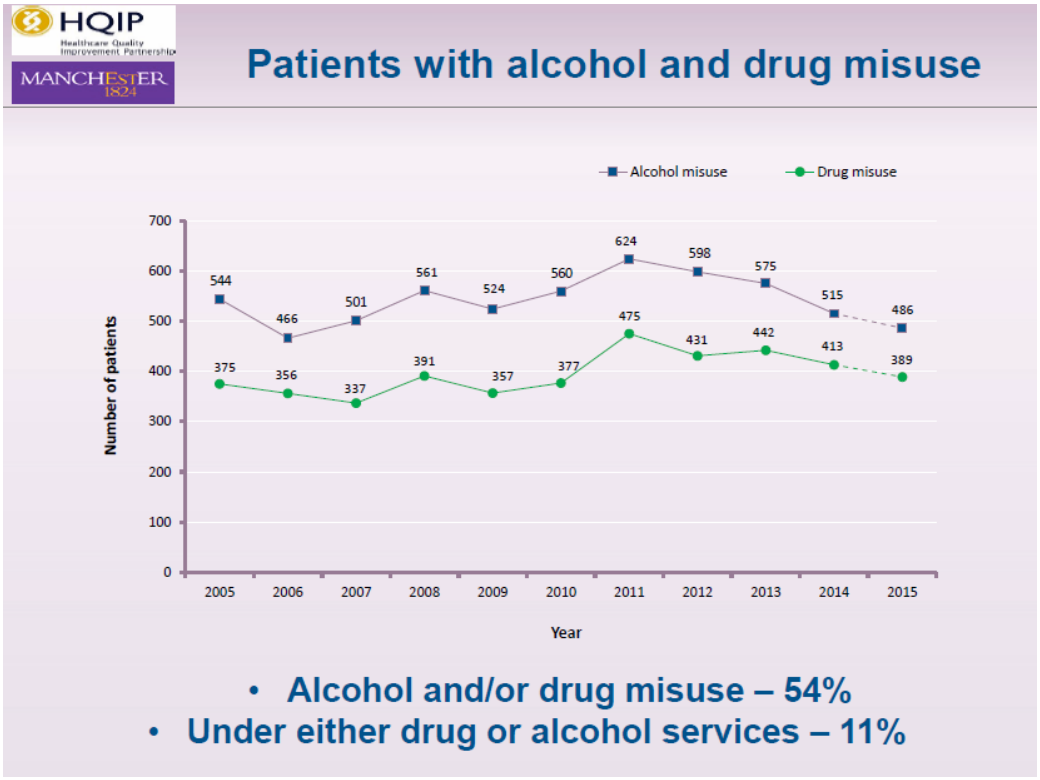
Further analysis from the National Confidential Inquiry has shown that 90% of suicides amongst people known to secondary mental health services are occur in community (rather than inpatient settings). Of these, and as Slide 2 shows below, one of the highest risk points is in the first two weeks after discharge from an inpatient setting.

Slide 2 – Suicides per week after discharge, patients known to mental health services



The National Confidential Inquiry has also identified that alcohol and drug misuse is also a risk factor for suicide. Amongst people known to secondary mental health services who die by suicide, alcohol and/or drugs were misused by 54% (as shown in Slide 3 below)

Slide 3 – Substance misuse in patients known to mental health services who die by suicide



3.6.3 People who have a history of self-harm

Not everyone who dies by suicide will have previously self-harmed, and not everyone who self-harms will go onto end their own lives. However, according to the National Confidential Inquiry into Suicide and Homicide it is the single biggest indicator of risk. As Slide 3 shows, 50% of people who die by suicide have a history.

Slide 3 – Self-harm links to suicide from the National Confidential Inquiry

Table 3 below shows the numbers of individuals in Kent attending A&E after self-harm incidents. The number of females between the ages of 10-19 attending A&E after self-harm is more than double the number of males aged 10-19. However, the number of males between 20-29 is higher than the number of females in the same age band.

Table 3 - Numbers and percentages of A&E self-harm attendances, Kent Residents, 2011/12 - 2015/16 (pooled), by gender and age band

	Males		Females		Total	
Age band	**Numbers**	**% of total**	**Numbers**	**% of total**	**Numbers**	**%**
10-19	1,059	7.7	2,158	15.7	3,217	23.4
20-29	1,799	13.1	1,635	11.9	3,434	25.0
30-39	1,235	9.0	1,011	7.4	2,246	16.4
40-49	1,242	9.0	1,296	9.4	2,538	18.5
50-64	1,072	7.8	614	4.5	1,686	12.3
65+	387	2.8	229	1.7	616	4.5
Total	**6,794**	**49.5**	**6,943**	**50.5**	**13,737**	**100**

Source: SUS, KPHO (JB)

Table 4 shows the numbers of individuals in Kent being admitted to hospital after self-harm incidents. The number of females between the ages of 10-19 being admitted to hospital after self-harm is more than four-times the number of males aged 10-19.

Table 4 - Numbers and percentages of emergency admissions for self-harm, Kent Residents, 2011/12 - 2015/16 (pooled), by gender and age band

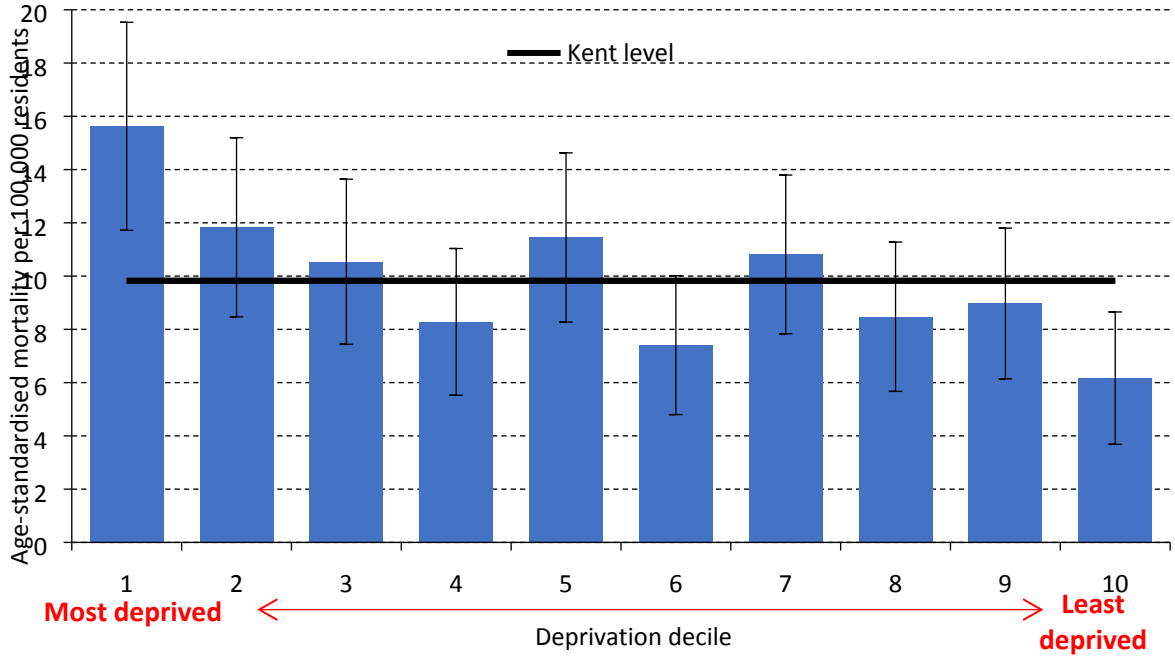
	Males		Females		Total	
Age band	**Numbers**	**% of total**	**Numbers**	**% of total**	**Numbers**	**%**
10-19	618	4.1	2,480	16.4	3,098	20.5
20-29	1,584	10.5	2,238	14.8	3,822	25.3
30-39	1,127	7.5	1,401	9.3	2,528	16.7
40-49	1,199	7.9	1,853	12.3	3,052	20.2
50-64	836	5.5	1,057	7.0	1,893	12.5
65+	303	2.0	426	2.8	729	4.8
Total	**5,667**	**37.5**	**9,455**	**62.5**	**15,122**	**100**

Source: SUS, KPHO (JB)

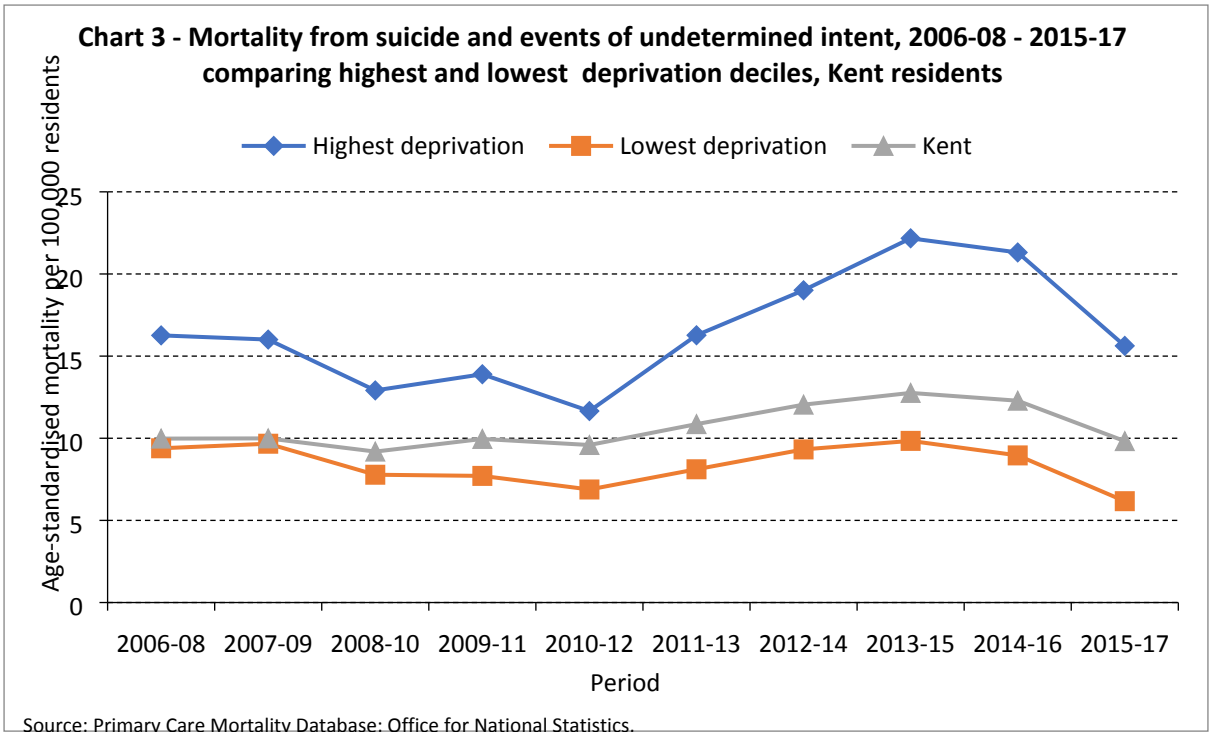
3.6.4 Deprived communities

There is a strong link between suicide rates in Kent and areas of greatest deprivation. Charts 2 and 3 show that the most deprived communities in Kent consistently have the highest suicide rates.

Chart 2 - Mortality from suicide and events of undetermined intent, 2015-17 by deprivation decile (Dn), Kent residents



Source: Primary Care Mortality Database; Office for National Statistics,



Source: Primary Care Mortality Database: Office for National Statistics.

3.6.5 Children and young people

Between 2012 and 2016, 54 people aged 24 and under died due to suicide or undetermined causes in Kent. Of these, 8 (16%) were aged under 18. The number of people under 18 who die from suicide or undetermined causes is low, however the impact on family, friends and communities is so severe that they remain a group to prioritise for support.

The small numbers mean that providing analysis at a lower geographical level than Kent, or analyzing single year data is not possible.

3.6.6 Other high-risk groups

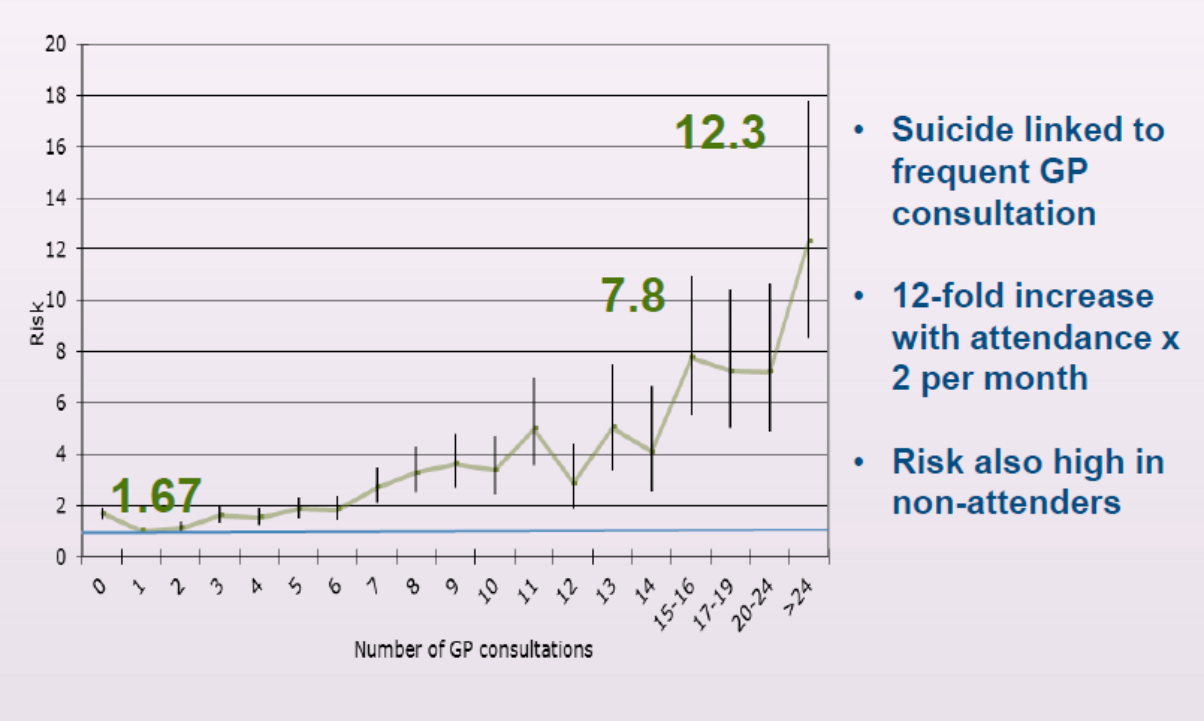
National evidence shows that the following groups also have higher rates of suicide that the general population:

- People in contact with the criminal justice system
- People with co-existing substance misuse and mental health conditions
- People who have been bereaved by suicide
- People with long term physical health conditions
- Groups who experience discrimination or abuse (eg LGBT or some BME groups)
- Students

3.7 Primary care

The National Confidential Inquiry has identified that individuals that visit their GPs more than 24 times a year have a much higher risk of dying by suicide than individuals who visit their GPs less often (see Slide 4 below).

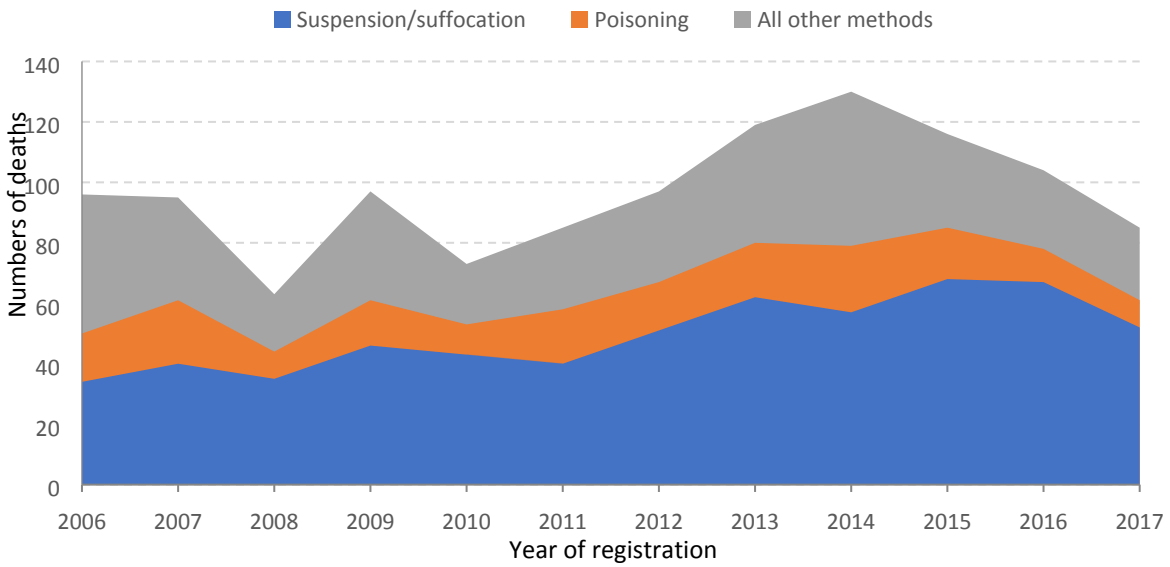
Slide 4 – Suicide risk and GP attendance



3.8 Suicide method

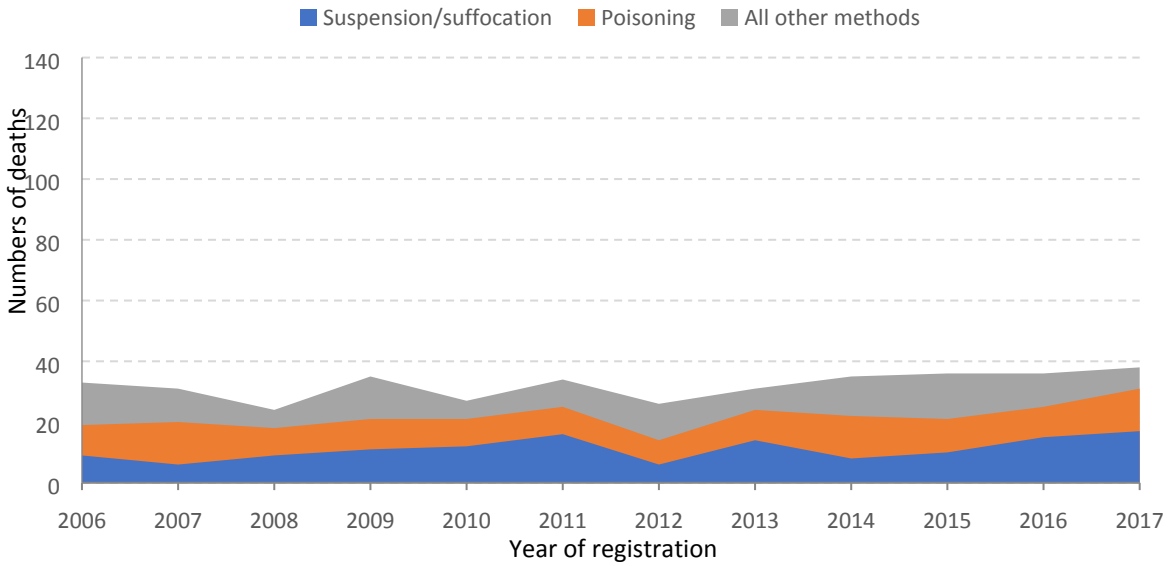
As shown in Charts 4 and 5 below, suspension and poisoning are the two most common methods of suicide for both men and women, however suspension makes up a larger proportion of deaths amongst men than women. Jumping (from a height or in front of a vehicle) makes up the largest part of "All Other Methods".

Chart 4 - Deaths from suicide and events of undetermined intent, Kent, 2006-2017 by method, MALES



Source: PCMD, KPHO (JB)

Chart 5 - Deaths from suicide and events of undetermined intent, Kent, 2006-2017 by method, FEMALES



Source: PCMD, KPHO (JB)

4. Conclusions

4.1 Conclusions

Despite small falls in the numbers of people taking their own lives in recent years, suicide remains a key public health priority, accounting for nearly 1% of all deaths in Kent.

The Kent and Medway Suicide Prevention Steering Group is a strong network of professional agencies, charities and individuals affected by suicide, however the current Kent and Medway Suicide Prevention Strategy is due to end in 2020. Plans should be put in place to develop a further five-year strategy.

The additional funding received in 2018/19 will raise the profile of suicide prevention issues within Kent and Medway, and is an opportunity for existing programmes to be strengthened, new innovations to be tested and system-wide changes to be embedded. The funding programme should be evaluated fully with key learning points transferred into future programmes.

4.2 Recommendations

1. Continue to implement the Kent and Medway 2015-2020 Suicide Prevention Strategy and Action Plan
2. Continue to implement and evaluate the 2018/19 STP Suicide Prevention funding programme
3. During 2019, develop a new Kent and Medway Suicide Prevention Strategy for 2020-2025