Bristol JSNA Chapter 2018

Suicide Prevention and Self-harm

Chapter information	
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Linked JSNA chapters	

This Joint Strategic Needs Assessment Chapter is being produced in parallel with the Suicide Prevention Strategy for Bristol. It also forms part of the city-wide mental health programme 'Thrive Bristol'.

Executive summary

Introduction

Suicide is defined as: the taking of one's own life voluntarily and intentionally. Every suicide death is a tragedy and impacts on family, friends, support services, health care professionals and society as a whole. Alongside the enormous personal loss, the economic cost of one person's suicide is estimated at approx. £1.67 million (at 2009 prices) (1).

In the UK suicide deaths are determined by a coroner, as a coroner's inquest is required for any death that is violent or unnatural, occurs under police custody, or is sudden and of unknown cause. The coroner will only record a suicide conclusion if there is an indication of suicidal intent "beyond reasonable doubt". This is the criminal standard of proof rather than the civic standard. An open conclusion is when the coroner does not have enough evidence. Alternatively a narrative conclusion may be made, setting out the facts surrounding the death in more detail. (2) Due to the burden of proof required for a suicide conclusion, it has been estimated that there was an underestimation of suicides in the UK by around 30% and as much as 50% among young people. (3The potential underestimation is overcome by ONS as they combine deaths classified as either suicide or undetermined. They also review all narrative conclusions to determine likelihood of suicide and classify accordingly.

Suicide is one of the leading causes of premature mortality worldwide. In the UK in 2017 there were 5,821 deaths by suicide. This equates to 16 people dying by suicide every day. In 2016, 83 residents of Avon (BANES, Bristol, North Somerset and South Gloucestershire) have died of suicide: 7 per month on average. In Bristol, on average, there are 47 suicide deaths per year (based on the last 10 years of data of registered deaths). *Source: Primary Care Mortality Database 2018, NHS Digital*

Key issues and gaps

The Government's **'Preventing Suicide in England'** (4) document sets six national priorities for suicide prevention:

- Reducing the risk of suicide in high risk groups: in Bristol suicide deaths are higher than the national average amongst middle aged men
- Tailoring approaches to improve mental health in specific groups
- Reducing access to means of suicide: Bristol has one of the UKs leading high frequency suicide locations. There are on average four fatalities from the Clifton Suspension Bridge and Avon Gorge annually.
- Providing better information and support to those bereaved or affected by suicide: there are gaps in the provision of support in Bristol, from contingency information for schools to improving the pathway for bereaved families.
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
- Reducing rates of self-harm as a key indicator of suicide risk: Self-harm and admission to hospital is higher in Bristol than elsewhere in the UK.

Recommendations
Bristol's key aims for suicide prevention: ❖ Update Bristol's Suicide Prevention Strategy along with measurable action plans. ❖ Focussed suicide prevention action plan around children and young people in Bristol which acts upon learning from recent suicides. ❖ Implementing evidence-based self-harm interventions – such as increasing the proportion of hospital-presenting who have a psychosocial assessment. ❖ Partnership working between coroners, the police and public health to ensure real-time monitoring and coordination; and support offered to those bereaved by suicide. ❖ Reducing access to means.

JSNA chapter report

A: What do we know?

1) Who is at risk and why?

Suicide is the act or an instance of taking one's life voluntarily and intentionally. Suicidal behaviour is the end result of the complex relationship between many factors that are biological, psychological and environmental in nature. An individual's risk of suicide is determined by many factors. These include demographic factors such as age and sex, poverty and deprivation, occupation, physical illness, drug and alcohol misuse and mental ill-health. (5)

The Suicide Prevention Strategy for England 2012 (4) identified the following at risk groups; males, people who misuse alcohol and drugs, people in the care of mental health, people with a history of self-harm, people in contact with the criminal justice system and certain occupational groups.

Males

Three in four suicides in the UK are by men, the highest rate amongst men aged 45-59 years. Men are at threefold greater risk of suicide than women. Suicide is the single biggest killer of men aged 20-49 in England and Wales, with 78% of all suicides in that age group in 2016 being men. (8) It is important to consider other factors that may impact men such as relationship problems, financial difficulties and alcohol/drug problems. Men living in the most deprived areas are 10 times more likely to end their lives than those in the most affluent areas.

People who misuse alcohol and drugs

The misuse of drugs and alcohol is strongly associated with suicide in the general population. Drugs, alcohol and suicide thoughts can be a lethal combination. Alcohol affects a suicide risk in multiple ways. It increases impulsivity in people who are already suicidal. It can also impair decision making process and exacerbate feelings of depression and worthlessness. Alcohol dependence often leads to social decline e.g. break of marriage, loss of job and relationships. (6)

The connection between drug use and suicide is not as clear. Though local research (ALSPAC) indicates drugs such as cannabis may increase the likelihood that an individual with suicidal thoughts acts on those thoughts. (7) Drug use carries the risk of overdose so it is not clear whether the overdose it intentional suicide or accidental. Drug use can increase impulsivity and risk-taking behaviour.

People in the care of mental health services and people with a history of self-harm

People under the care of mental health services, especially those in psychiatric hospitals or under the crisis teams and those who self-harm are at increased risk. Self-harm is a term used to describe all intentional harm to self, including suicide attempts. People who frequently present to hospital following self-harm are a particularly vulnerable group. Self-harm is the strongest risk factor for completed suicide, with half completed suicides having previously self-harmed.

People in contact with the criminal justice system

People at all stages within the Criminal Justice System including people on remand and those recently discharged from custody, are at high risk of suicide.

Specific occupational groups, such as low skilled workers e.g. construction and carers. For males working in skilled trades, the highest risk was among building finishing trades particularly plasters,

painters and decorators. For females the risk of suicide among health professionals was 24% higher than the female national average; this is largely explained by female nurses. Unemployment is also a risk factor for suicide. (8)

In addition there are groups of people with particular vulnerabilities, or have problems with access to services, who should also be considered:

- *Children and young people*
- *Survivors of abuse or violence*
- *Veterans*
- *People living with long-term physical health conditions*
- *People who are especially vulnerable due to social and economic circumstances*
- *Lesbian, gay, bisexual and transgender people*
- *Some ethnic groups*
- *People who are bereaved or affected by suicide*

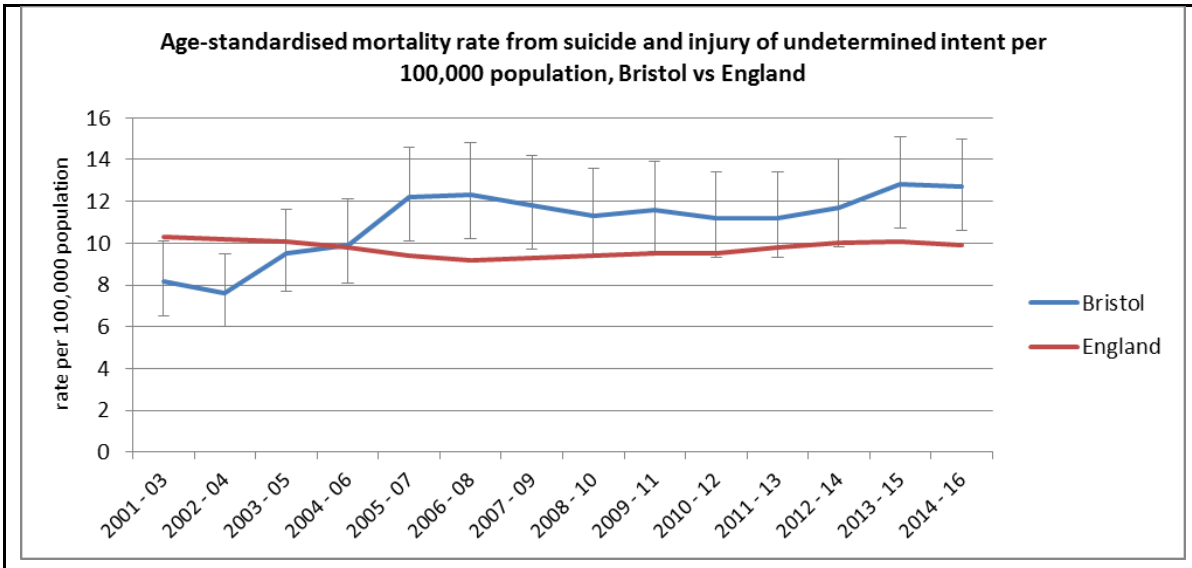
Media reporting

There is strong national and international evidence that reporting about suicide is different to reporting about any other story, and can impact on the future behaviour of readers/viewers/listeners. Reporting about specific suicides can lead to increases in suicide. People vulnerable to suicide, or those in despair, may be negatively impacted by suicide reporting. Details of location, method, and identifying individuals can impact them. Stories that sensationalise the suicide, or report specific methods as quick, easy or painless or that the suicide achieved something – e.g. forced bullies to apologise, can impact negatively on the viewer/reader. (9,10)

2) What is the size of the issue in Bristol?

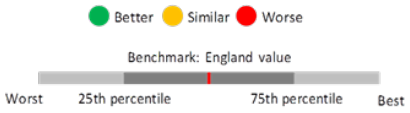
Although suicide rates fell between 1981 and 2007 in England, since then there has been a steady increase up to 2013-2015 (10.1) and a small decrease in the 3 years average rate to 9.9 per 100,000 people aged 10 and over in 2014-2016 (11).

The current 3 years average suicide rate in Bristol is 12.7 per 100,000: 28% higher than the national average of 9.9. According to Public Health England there were 140 suicide deaths registered in Bristol in 3 years, between 2014 - 2016. 69% (97) of those deaths were among males and 31% (43) among females. (11)



Bristol is worse than the average for England in 8 areas:

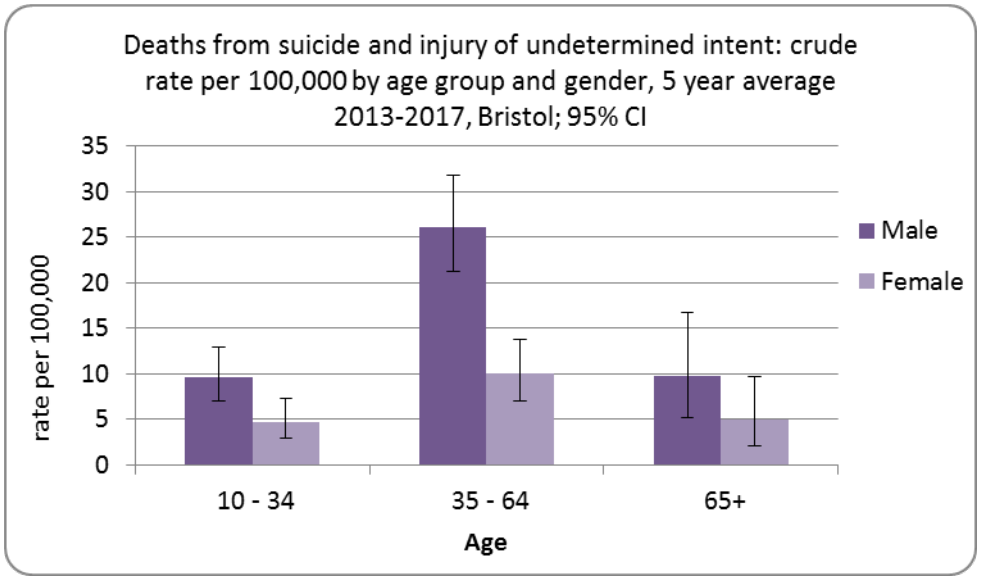
- 3 years average suicide rate among persons
- 3 years average suicide rate among females;
- years of life lost due to suicide rates among persons
- years of life lost due to suicide rates among females;
- suicide rates among females 10-34 years old;
- suicide rates among males 35-64 years old
- suicide rates among females 35-64 years old
- suicide rates among females aged 65 and older. (11)



		Bristol		SW Region	England	England		
Indicator	Period	Count	Rate	Rate	Rate	Lowest	Range	Highest
Suicide: age-standardised rate per 100,000 population (3 year average) Persons aged 10+	2014-16	140	12.7	10.8	9.9	6.1		18.3
Suicide: age-standardised rate per 100,000 population (3 year average) Males aged 10+	2014-16	97	18.0	16.0	15.3	8.4		27.7
Suicide: age-standardised rate per 100,000 population (3 year average) Females aged 10+	2014-16	43	7.4	5.9	4.8	2.3		11.3
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) PERSONS	2012-14	131	39.7	35.6	31.9	10.7		62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) MALES	2012-14	95	57.6	52.6	50.2	16.4		101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) FEMALES	2012-14	36	21.2	18.6	13.7	0.0		26.2
Suicide crude rate 10-34 years: per 100,000 (5 year average) MALES	2011-15	49	11.1	10.8	10.5	4.5		25.3
Suicide crude rate 10-34 years: per 100,000 (5 year average) FEMALES	2011-15	22	5.1	4.0	2.9	2.5		5.1
Suicide crude rate 35-64 years: per 100,000 (5 year average) MALES	2011-15	105	27.5	22.2	20.8	8.9		39.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) FEMALES	2011-15	31	8.4	7.1	6.0	5.0		8.4
Suicide crude rate 65+ years: per 100,000 (5 year average) MALES	2011-15	13	10.1	13.6	12.6	2.9		26.2
Suicide crude rate 65+ years: per 100,000 (5 year average) FEMALES	2011-15	9	5.6	5.6	4.4	3.7		5.6

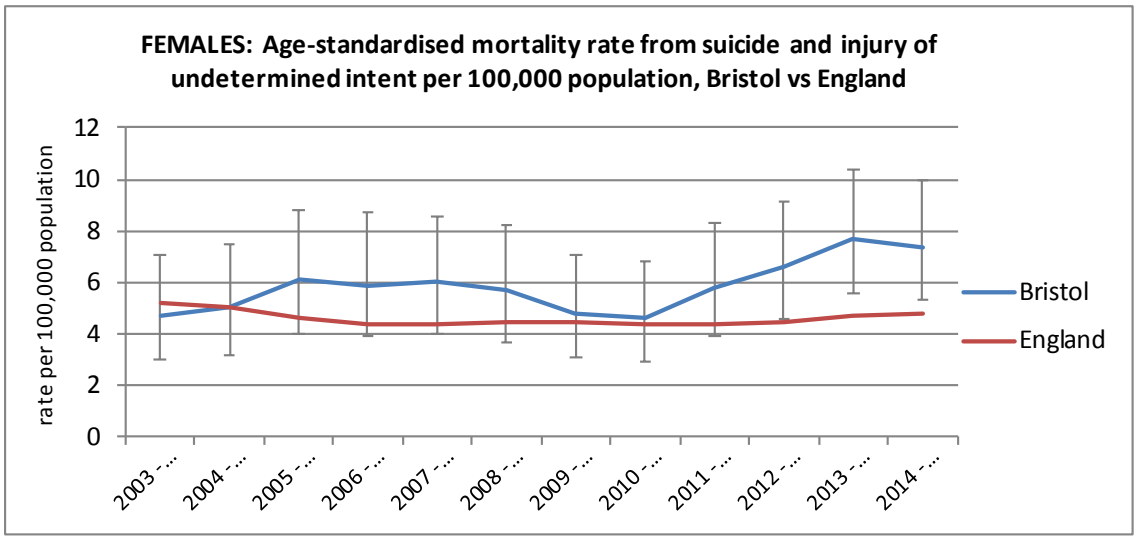
Gender

UK suicide rates among men are three times those of women, and this is replicated in Bristol. The male suicide rate is more than three times higher than the female rate, with 15.3 male deaths per 100,000 compared to 4.8 female deaths on average in 2014-2016. Middle aged men are the highest risk group in the UK. It is particularly high in Bristol (at 26.1 per 100k, compared to the UK rate of 20.8): this chart shows Bristol suicide deaths by gender:



Source: Primary Care Mortality Database 2018

However, the suicide rate for women is 7.4 per 100,000: the 10th highest in England's unitary authorities and the highest among the core cities in England



People under the care of mental health services

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017) report estimates that about 27% of general population suicides in England were identified as patient suicides between 2005 and 2015 (i.e. the person had been in contact with mental health services in the 12 months prior to death). (13) Within Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) there has been a significant fall in the rate of suicide from 11.4 to 8.6 per 10,000 in 2012-2014. However, this is consistently higher than the national average for the rest of the English NHS Trusts. (14)

People who misuse alcohol and drugs

Bristol has a higher than average prevalence of opiate and/or crack cocaine use, high numbers of drug related deaths, higher than average admission to hospital due to alcohol and higher than average estimated prevalence of adults with alcohol dependence. (14)

People in contact with the criminal justice system

The rate of self-inflicted deaths in prison custody in 2017 was 1.1 per 1,000 prisoners (97 deaths). (14) Bristol Prison is a category B male prison, with the majority staying 12 months or less. It has an operational capacity of 614.

Number of deaths in the HMP Bristol

Bristol prison:	2005-07	2008-10	2011-13	2014-16
Apparent self-inflicted deaths:	<5	<5	<5	7
Apparent natural cause deaths:	<5	<5	<5	<5

People with a history of self-harm

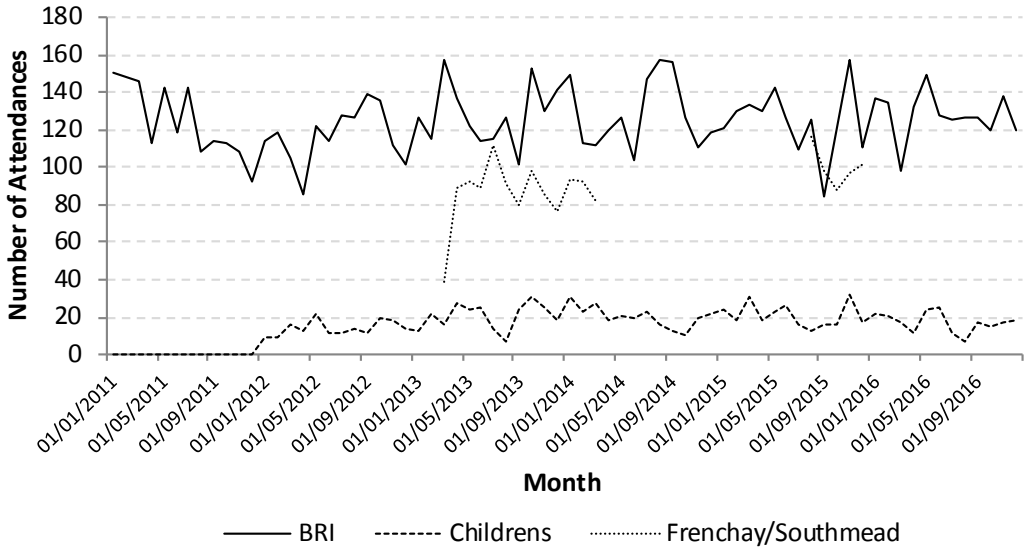
Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress. Self-harm whether involving intentional self-poisoning or self-injury is the most important risk factor for subsequent death by suicide. While most people who self-harm do not die by suicide, around 50% of people who die by suicide have a history of self-harm. (3)

The Bristol Self-Harm Surveillance Register is a database maintained in the emergency department of the Bristol Royal Infirmary and has been recording detailed information on patients presenting to hospital for self-harm since September 2010.

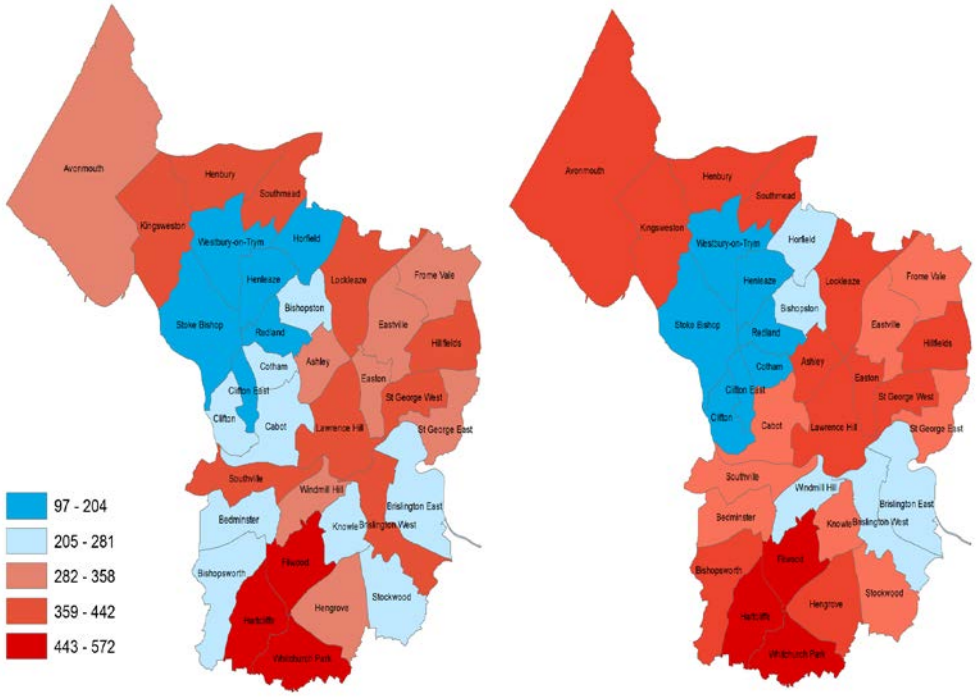
Hospital admission following self-harm in Bristol is higher than the national average. In Bristol self-harm accounted for 3640 Emergency Department attendances and admissions to local hospitals (Bristol Self-harm Surveillance Register, 2017). 57 people who presented for self-harm at the Bristol Royal Infirmary between 2011 and 2015 have gone on to die by suicide (BSHSR). Approximately 15% of all suicides in Bristol occur to people attending hospital following self-harm in the previous 12 months.

During the calendar year of 2016, 42% of people who died in Avon (Bath and North East Somerset, Bristol, North Somerset and South Gloucestershire) had a recorded history of self-harm. For females this was 50%.

Number of self-harm attendances per month at the Bristol Royal Infirmary, Bristol Royal Hospital for Children and Frenchay/Southmead Hospital*, 2011-2016.



The following map shows self-harm (left) alongside deprivation percentile in Bristol (right) 2015:



Source: Bristol Self-harm Surveillance Register annual report 2015

Students

There have been a number of suicides among the student population in Bristol over the last 2-3 years. This has been classified as a cluster under the Public Health England guidance. (16)

Suicide methods

Table 1 reports the method of suicide in Bristol between 2008 and 2017. Hanging was the most common method of suicide followed by poisoning.

Table 1 Bristol mortality from suicide and injury of undetermined intent 2008-2017 by gender and cause

Cause of death	Male	%	Female	%
Hanging	173	55.3%	43	38.1%
Self-poisoning	56	17.9%	37	32.7%
Fall/jump	40	12.8%	18	15.9%
Carbon monoxide	12	3.8%	3	2.7%
Drowning	13	4.2%	3	2.7%
Other	19	6.1%	9	8.0%
Total	313		113	

Source: Primary Care Mortality Database 2018

Location of death

Table 2 shows the number of deaths from suicide and injury of undetermined intent in Bristol by place of death

Bristol has a heightened risk of suicide in public places, primarily due to the Clifton Suspension Bridge and Avon Gorge. There is also frequent use of public places such as the local rail network, car parks. Restricting access to means is one of the most evidenced aspects of suicide prevention as well as improving opportunities for intervention but can be difficult to achieve.

Table 2 *Number of deaths from suicide and injury of undetermined intent in Bristol by place of death*

Place of death	***Number of deaths***	***%***
Home	*227*	*53.3%*
Public Place	*86*	*20.2%*
Avon Gorge/Portway area	*47*	*11.0%*
Hospital	*47*	*11.0%*
Other	*19*	*4.5%*

3) What is the evidence of what works (including cost effectiveness)?

'Preventing Suicide in England: a Cross Government Outcomes Strategy to Save Lives' has set clear and evidence based priorities for local suicide prevention groups. It gives the six key focus areas for action. This was expanded to include self-harm in the Third progress report on Preventing Suicide in England. (7,17)

Reduce the risk of suicide in key high-risk groups and improve mental health in specific groups

There is very little evidence on reducing the risk among high risk groups, particularly among those that are not engaged in mental health services. There is need to develop evidence in this area. There is some evidence that sporting communities are an important way to engage with young and middle aged men.

Training programmes for suicide prevention such as ASIST (2 days) and safeTALK (1/2 day) can improve the knowledge skills and attitudes of professionals and the community. Although no evidence exists of suicide reduction via training there is evidence around increased knowledge, motivation, confidence and reduced stigma which can reduce suicide. These training packages need to have ongoing provision and top up training ever 2-3 years and a clear target audience strategy: gatekeeper training, general awareness or skills based training. The training needs to be tailored to skills and needs of the audience.

All those working with high risk groups should have access to ASIST, including those working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems.

Reduce access to means of suicide

Around a third of all suicides take place outside the home, in a public location of some kind. The Preventing suicides in public places guidance (16) states that there are four broad areas of action that can help eliminate suicides at frequently-used location.

Area 1 Restrict access to the site and means of suicide e.g. by denying access or installing barriers
Area 2 Increase opportunity and capacity for human intervention e.g. improved surveillance and

suicide awareness training
Area 3 Increase opportunities for help seeking behaviour e.g. signage and provision of help-line numbers
Area 4 Change the public image of the site e.g. ensure media reporting is in line with Samaritans guidelines.

Provide better information and support to those bereaved or affected by suicide
Public Health England's guidance, Support after a suicide: A guide to providing local services provides guidance on delivery support after a suicide. (19) The term postvention describes activities developed by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation. Specific actions for postvention services include

- effective and timely emotional and practical support for families bereaved or affected by suicide
- effective responses to the aftermath of a suicide
- information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

Support the media in delivering sensitive approaches to suicide and suicidal behaviour
Research has shown that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The risk has been noted to increase when the media story describes suicide method explicitly, uses a graphic or dramatic headline or image, and repeatedly or extensively. There is evidence that stories describing people overcoming suicidal crises may have a positive effect on reducing suicide rates.

There is good evidence of how sensible, sensitive reporting of suicide can improve the experience of the bereaved as well as contribute to prevention. Language needs careful attention – using terms such as such as 'end life by suicide rather than 'commit suicide', providing context to the death, framing suicide as tragic and avoidable and promoting help seeking are all examples of ways in which media reporting can change negative behaviour and lead to a fall in suicide rates.

Reducing rates of self-harm as a key indicator of suicide risk
The Government's Five Year Forward View cites liaison psychiatry services based in Emergency Departments (A+E) as one of the key mechanisms for mental health service improvement. There is NICE evidence that the psychosocial assessment following self-harm does reduce repeat attendance at hospital.

4) What services / assets do we have to prevent and meet this need?

There is an established suicide prevention steering group with local stakeholders three times a year steering meetings, and widespread, multiagency engagement. In addition the Avon Suicide Data review Group works closely with the Avon Coroner to improve data collection.

Reducing the risk of suicide in high risk groups
Men
There are national helplines for young men e.g. CALM, State of Mind sport, Samaritans.
The Sanctuary provides support to people of all ages and gender: a specific café style supportive space used by people in mental health distress on Thursday, Friday and Saturday nights.
Bristol has some excellent emerging initiatives, which as yet do not have evidence but are well

utilised and liked by suicidal men. For example the group Changes (part of Time to Change) has groups running in locations across the city for men's support and some local anti-stigma initiatives such as BASA's football fun day. Organisations across Bristol are signing up to the Time to Change mental health pledge including the University of Bristol.

Deprivation and homelessness
There has been a great deal of research and support for those in more deprived areas of Bristol. As well the work outlined for young people, the University of Bristol HOPE research study piloted an approach to target support to people who had attempted suicide as a result of debt, employment and benefit problems.

Children and young People
Bristol Public Health have made great inroads into prevention initiatives and promoting good mental health. CASCADE mental health training has going into all Bristol schools, and targeted Youth Mental Health First Aid Training is being given to targeted secondary schools in Bristol. 10 heads of wellbeing have been appointed in deprived areas to support good emotional health. Bristol University, in collaboration with Cardiff University, are leading a large cluster randomised controlled trial aimed at improving the mental health and mental health literacy of teachers. Several secondary schools in Bristol are participating.

People in the care of mental health services, including inpatients
The CCG and police (as part of the national Crisis Concordat) have been developing Street Triage, helping the police identify those at risk and supporting them in receiving appropriate help from citywide agencies.

People in contact with the criminal justice system
The Samaritans are working in prisons and prison services around buddying and training for support to those in prison.

Reducing access to means of suicide
A multiagency group has been convened and is working towards reducing access: this has a strong evidence base and has the potential to save approximately four lives per year. This group is working to reduce access where feasibly possible.
Transport police and Network rail in collaboration with Samaritans are training their staff in identifying and responding to high risk individuals on the rail network.

Providing better information to support those affected or bereaved by Suicide
Samaritans, Survivors of Bereavement by Suicide (SOBs) and Cruse all provide supportive services for people who have lost a loved one to suicide. There are facilities and signposting at the coroner's court to help bereaved loved ones. However, we have no clear standard in Bristol about how we identify, monitor and help this group of people more systematically. For example, care providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved ones.

Supporting the Media
Bristol City Council's communication department monitor the reporting of suicide in the local press. Professor David Gunnell and the Samaritans have run training sessions with Bristol Post editors and journalists.

Reducing rates of Self-harm
Bristol support services for self-harm are wide ranging. Notably the Self-Injury Support and the Self-Injury Self Help groups in Bristol provide a comprehensive range of support services and contribute to local research.

There is high level of engagement across Bristol of the two universities, public health, Bristol City Council, the CCGs and patients themselves via Bristol Health Partners (BHP), with support for evidence based practice by NIHR CLARHC. As part of BHP Bristol has an improving care in self-harm Health Integration Team (STITCH HIT) - which brings together stakeholders in self-harm care with the aim of reducing suicide.

5) Local views

In Bristol in early 2017 a 'stakeholder' group was held as part of Bristol suicide prevention planning. This group included experts by experience from key areas of this work including those bereaved by suicide and Bristol Independent Mental Health Network (BIMHN) – representatives of those under the care of mental health services in Bristol. The group agreed key areas to target for action which largely align with the national strategy:

- media
- students
- mental health
- self-harm
- access to means (suspension bridge)
- support for those bereaved by suicide

B: What does this tell us?

6) Key issues and gaps

Because suicide is multifactorial in nature it is very important as a city we try to identify emerging patterns of risk / risk factors locally and nationally. There are number of key issues for Bristol: high rates of suicide among middle aged men, increasing rates among women. It is unclear why the rate of suicide is high among women in Bristol.
The recent cluster of student suicides emphasises the importance of establishing real time surveillance, important lessons learned and an urgent need for contingency planning.

There is a significant number of deaths in the Avon Gorge/Portway area with frequent reporting of Clifton Suspension Bridge in the local media. A review of safety on the Clifton Suspension Bridge and along the gorge should be considered.

Bristol has many areas of social deprivation. There is a need for more wellbeing and suicide prevention strategies in the deprived areas, especially targeting men. There are many exciting and positive initiatives with less direct evidence for suicide prevention but impact on reducing stigma, improving mental wellbeing and improving confidence and knowledge. This needs to be captured, monitored and audited. Some of these initiatives will overlap the mental health strategy.

There is some evidence for ASIST training. It would be useful to review the training available within Bristol and assess its impact. It may be possible to target specific workers at risk of suicide identified by the national strategy: specific occupational groups such as construction workers, nurses, carers. It may be worth exploring targeting men in the workplace.

C: What should we do next?

7) Recommendations for consideration

The Suicide Prevention Steering Group, the Suicide Prevention Strategy for Bristol and the Suicide Prevention Action Plan for Bristol all need updating and revitalising. They need to be open and transparent including being open to the public, with an action plan that has named responsibility and accountability.

The recent tragic cluster of student suicide in Bristol has been a wake-up call to local services. We need surveillance systems in place to identify and respond to future clusters. We need to ensure lessons are learned from these recent deaths.

We have a good data collection and information sharing arrangement, but we need further improved partnership working with the Coroner's Office, police and public health services. This will have two purposes: firstly, to ensure location and method specifics are logged so that we can quickly identify any emerging cluster. Secondly, to ensure timely support is available for people bereaved by suicide. We need to be assured that provision matches need. Information needs to be shared quickly with established local services so that support can reach this vulnerable group of people and there is easily accessible contingency planning for schools and colleges.

Self-harm care in the city is enhanced by the multi-partnership working in STITCH. However there remains room for improvement, particularly in the funding of evidence-based interventions (such as psychosocial assessments, CBT) for this vulnerable group of people.

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