Living Well

Suicide and Self Harm

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Introduction

The topics covered in this section range from self harming behaviour with no suicidal intent to the suicidal behaviours of people who fully intend to end their lives and succeed in doing so.

Although suicide and self harm are included as one heading it is important to remember that self harm with no suicidal intent and suicidal behaviour differ in terms of intention, frequency, and severity. A person who self harms with no suicidal intent does not intend to end their own life and do not believe that death will result as a consequence of their behaviour; self harm with no suicidal intent is more common than suicidal behaviour and behaviours associated with self harm without suicidal intent cause less physical harm (such as cutting, burning, and biting as opposed to overdose, and hanging). Although self harm is acknowledged as one of several warning signs that a person may be vulnerable to suicidal thoughts, and between a quarter and a half of those who commit suicide have previously harmed themselves (Hawton and James, 2005); the vast majority of people who self harm will not go on to commit suicide. *Hamza et al (2012)* provide a detailed review of research into self harm as an indicator of suicidal behaviours.

Suicide is a devastating event. It is an individual tragedy, a life-altering crisis for those bereaved, and a traumatic event for communities and services. The impacts are immediately and profoundly distressing. Suicide is often the end point of a complex history of risk factors, so the prevention of suicide has to address this complexity.

Suicide is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides *(Department of Health, 2012).*

Self harm is when someone deliberately injures their body and includes a range of behaviours such as cutting, burning, punching, and poisoning. The behaviour is used by the individual as a coping mechanism to deal with underlying emotional distress *(NHS Choices).* People who self harm will often try to hide their behaviour making it difficult for others to offer appropriate support. Identifying that someone is self harming is the first step towards helping the individual to address the problems that are leading them to harm themselves.

What do we know?

Suicide: The Department of Health's (2012) national strategy for preventing suicide in England sets two major objectives - reducing the suicide rate in England and giving better support to people bereaved or affected by suicide.

The number of people who take their own lives in England has reduced over the past 30 years but has shown a recent increase since 2007 with rates currently (2013) as they were in 2004. This recent increase is driven by an increase in male suicides: rates for females have remained constant over the past ten years. Suicide contributes a significant proportion of avoidable deaths to young people and is the most common cause of death in young males. Although in the majority of cases suicidal thoughts first occur in late adolescence, the greatest number of deaths from suicide occurs in middle adulthood *(Hamza et al, 2012).*

The levels and circumstances surrounding suicide have been tracked for a number of years and this gives some clear information in order to better target prevention interventions at those at risk. Some risk factors are personal to individuals, such as concurrent mental health and substance misuse problems, whilst others are more to do with general economic conditions and financial pressures on households and individuals.

The average cost of a single completed suicide of a working age individual in England was estimated in 2011 to be £1.7 million *(Department of Health, 2011).* This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as waged and unwaged lost output, public service time and funeral costs. Non-fatal self harm also has major – potentially avoidable - cost implications for public services, particularly A&E and acute inpatient services and psychiatric follow-up.

Self harm: Self harm is much more common than many people may at first expect. A World Health Organisation (2013/14) study revealed that the number of teenagers who self harm has increased significantly in the past decade with 20% of 15 year olds reporting that they have self harmed in the past year. This can be compared to 6.9% reporting that they have self harmed in 2002.

The vast majority of self harm behaviours will not come to the attention of medical services as the severity of the physical harm is often low. This is particularly true of behaviours such as cutting. 90% of cases that do result in hospital care are for self-poisoning *(Hawton and James, 2005).*

Self harm is most common amongst young people (aged between 11 and 25 years) and figures from surveys suggest it is more common in females than males. However, this difference may partly be explained by the fact that males are more likely to engage in behaviours which are less likely to come to medical attention and/or are less likely to be identified as self harm (e.g. punching a wall) *(Self Harm UK).* There is also evidence that this gender difference becomes less with age *(Association for Young People's Health and the National Child and Maternal Health Intelligence Network, 2013).* This suggests that females may begin self harming at an earlier age.

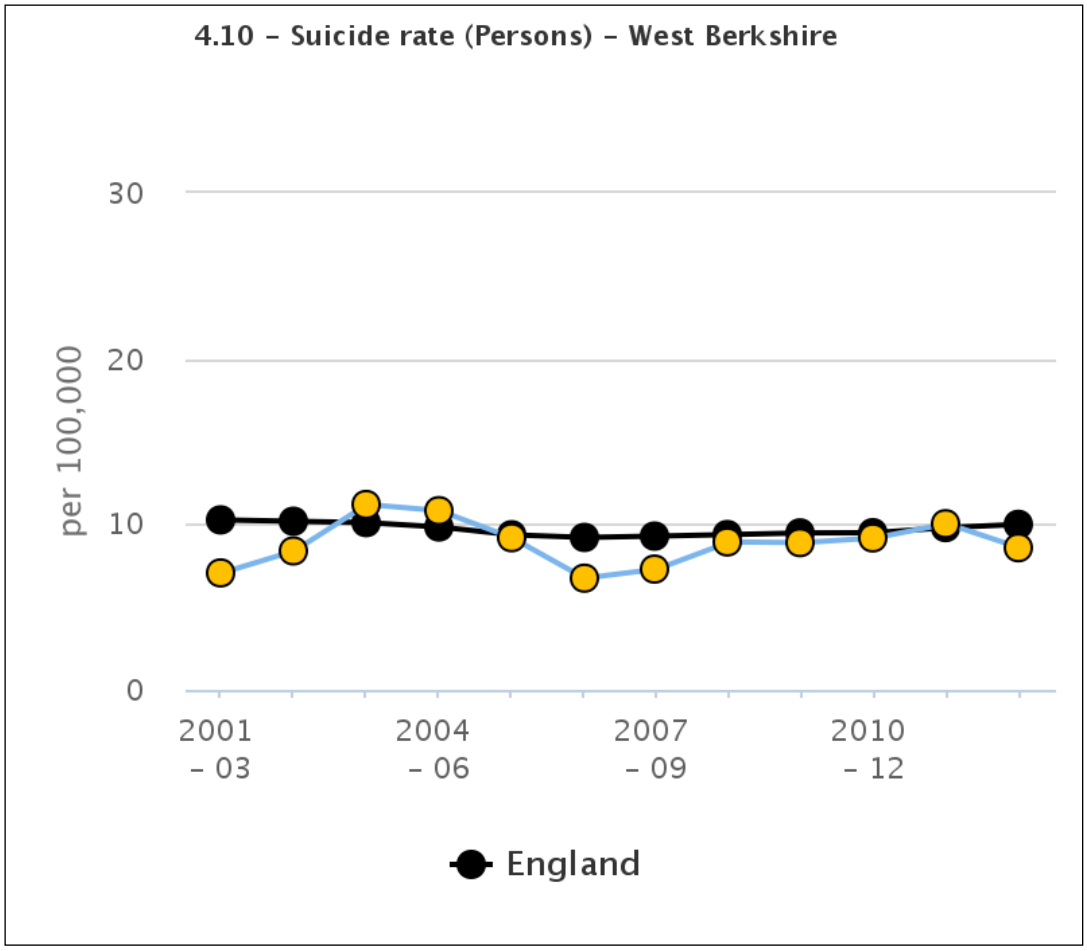
Risk factors which increase the likelihood of a person self harming are similar to those outlined as risk factors for suicide. Young South Asian females have an

increased risk of self harm with intercultural stresses and subsequent family conflict implicated *(Hawton and James, 2005).* However, it is important to recognise that self harm can affect anybody and does not happen to just one type of person *(Self Harm UK).* There are a number of common problems that can be experienced by anybody which are known to precede self harm including: difficulties with parents, bullying, low self esteem, and sexual problems. Alcohol and drug consumption increase impulsive acts including self harm.

Suicide: In 2012-14 there were 36 suicides or deaths of undetermined intent in West Berkshire. This is a rate of 8.6 per 100,000 persons, which is comparable to the England rate of 10.0 *(Public Health Outcomes Framework).*

Figure 1 shows the rate of suicides in West Berkshire over a 11-year period. As the numbers are small at a local authority level, it is difficult to comment on any significant trends or changes over this time.

Figure 1: Suicide rate per 100,000 people (2001-2014)

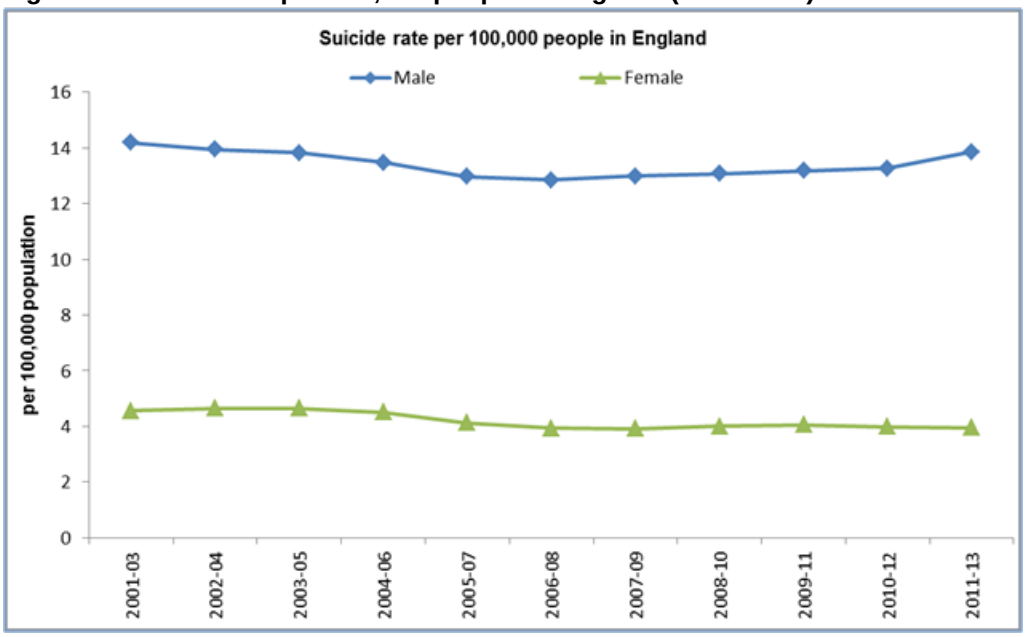


Source: Public Health Outcomes Framework

There are clear disparities between mortality rates between men and women. For the period covering 2011-13, 79% of suicides were male. Rates cannot be shown for most local authorities, due to small numbers. However, at a national level it is possible to see that the male suicide rate is around three times higher than the

female rate. Although females are more likely to attempt suicide than males, males are more likely to die from suicide (Hamza et al, 2012).

Figure 2: Suicide rate per 100,000 people in England (2001-2013)



Source: Public Health Outcomes Framework

The Department of Health's (2015) second annual report on the national strategy states that the suicide rates of middle-aged men have risen most since 2008. The strategy notes that: "this group are traditionally least likely to seek help, so that presents a challenge to services to be creative about improving access". The fall in suicide rates amongst younger men in the previous decade has also stalled and remains a leading cause of death for this group.

Public Health Teams in Berkshire have undertaken an audit of suicide and undetermined deaths during 2012-2014. Data for the audit was collected from Berkshire Coroner Office case notes for people who died from suicide or undetermined injuries during 2012-2014. The audit only includes Berkshire residents who died in the County. It is important to note that there can be a substantial delay between the date of death and the date of registration for suspected suicides, so it is likely that not all deaths from 2014 were included in the audit.

120 deaths were included in the Berkshire suicide audit for 2012-14 and showed:

- 70% of deaths were classified as suicide by the coroner and the other 30% were undetermined deaths/open verdicts.
- Males have a higher suicide rate compared to women in Berkshire, which is consistent with national figures (81% male; 19% female in 2012-14).
- 70% of the deaths recorded in 2012-14 were for people aged 30-59.
- The majority of people dying from suicide or an undetermined death in Berkshire were White-British. This is largely representative of Berkshire's population. In 2011, 73% of Berkshire's population were from a White-British background, ranging from 35% in Slough to 80% in West Berkshire. The

majority of deaths from other ethnic groups (Asian/Asian-British and White-Other) were Slough residents and this also reflects the Borough's population profile.

- There were more deaths from single people (40%), rather than those who were married, separated, widowed or co-habiting.
- 34% of deaths were from people who lived on their own. Recent data from the Office for National Statistics shows that 13% of usual residents in England and Wales were living on their own in 2011 and therefore these are over-represented in suicide deaths.
- The audit of people dying from suicide and undetermined deaths during 2012-2014 identified whether alcohol or prescribed drugs were detectable in the deceased. The analysis shows that at least 36% of people who died in 2012-14 had taken alcohol prior to their death and at least 42% had taken prescribed drugs.

As a result of the suicide audit, a local Suicide and Self Harm Prevention Steering Group was set up to provide a strategic multi agency response to suicide prevention across Berkshire. A local Suicide and Self Harm Prevention Strategy for Berkshire is in development and will include a framework for comprehensive actions across the "whole picture" in Berkshire and is being written in consultation with clinical leads, social care, public health, voluntary sector, providers, commissioners and users of services. Views are being sought from police, ambulance services, A & E liaison and transport police. This strategy localises the aims of the national strategy and identifies key objectives for Berkshire.

Self harm: There is very limited data which records the levels of self harm particularly at a local level. This is because it is a private behaviour and unlikely to be recorded unless the harm inflicted is severe enough for a person to attend hospital for treatment and self harm is recorded as the cause.

Hospital admission data where self harm was recorded for people resident in West Berkshire are given below and compared to England and the South East.

Figure 3: Emergency Hospital admissions for intentional self harm per 100,000 people in West Berkshire (2011-2015)

Time period	Number	Rate per 100,000	Compared to England	Compared to South East
2011/12	165	116	Lower	Lower
2012/13	203	137	Lower	Lower
2013/14	213	138	Lower	Lower
2014/15	198	127	Lower	Lower

Source: Public Health England

If we compare these figures to the estimates provided from survey data discussed earlier which indicate that as many as 20% of young people self harm it can be seen that only a very small minority of those who self harm are captured in the hospital admission data.

What is the data telling us?

The number of suicides in West Berkshire are small, however one suicide is one too many.

Suicide is not inevitable. Preventing suicides is a complex and challenging issue, but there are effective solutions for many of the individual factors which contribute towards the risk of suicide. Suicide Prevention work is cost-effective when conducted in accordance with evidence of effectiveness, and by working in partnership. Local Government, statutory services, the third sector, local communities and families each have a role to play in this.

The number of young people self harming in West Berkshire is likely to be much higher than hospital admission data suggests. Identifying that someone is self harming is the first step towards helping the individual to address the problems that are leading them to harm themselves. Recovery can be slow and difficult so it is vital that people are provided with understanding and support. Self harm can affect anyone and is often triggered by specific problems. Therefore, tackling the underlying triggers and encouraging the development of adaptive coping strategies can prevent the beginnings of self harming behaviour.

What are the key inequalities?: *The Department of Health's (2012)* national suicide prevention strategy identified middle aged men as one of the high risk groups who were a priority for suicide prevention. Suicide rates by age groups have remained the same since 1981, with the exception of the 45 to 59 age group for men.

Nationally, the highest UK suicide rate in 2013 was amongst men aged 45 to 59 at 25.1 deaths per 100,000. This is the highest rate for that age group since 1981 (*Office for National Statistics, 2015).* Men aged 30 to 44 have had the highest overall rate of suicide from 1981 to 2013.

Locally, the Berkshire suicide audits have shown that males have had a consistently higher suicide rate than females in Berkshire.

Self harming behaviours usually begin during adolescence and may begin earlier in females than males. There are some groups who may benefit from more targeted prevention such as adolescents with depression or in crisis.

Public Health England has recognised the specific inequalities in self-harm and suicide affecting lesbian, gay, bisexual and transgender people and the challenges in responding to this at local government level. As part of work to respond to this need, the Royal College of Nursing and Public Health England published a toolkit for nurses and health professionals that would enable them to develop their skills and knowledge around lesbian, gay and bisexual young people who are at risk of suicide and recognise the wider context of their mental health in relation to their sexual orientation and identity.

Other groups identified in the national strategy as requiring a tailored approach to ensure their suicide risk is reduced include:

- 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
- Black, Asian and minority ethnic groups and asylum seekers

What are the unmet needs/ service gaps?:

- Accessible information about support for men
- Early emotional resilience support for all
- Awareness among staff from statutory organisations
- Information about sources of support
- Support for those bereaved and affected by self harm and suicide

Recommendations for consideration

Commissioners and providers of services to consider how they can incorporate the following:

- Increasing individual and community emotional resilience
- Early identification and support for those at risk
- Awareness/training of staff in statutory organisations
- Widespread accessible information about support, for those in crisis
- Joined up early and timely support from the relevant statutory and voluntary groups to individuals in crisis and to those bereaved by suicide and or affected by self harm

Other services and partner organisations

West Berkshire Council, along with other councils in Berkshire, are working with the charity Campaign Against Living Miserably (CALM) to help support men. In September 2015, the UK's third 'CALMzone' was launched across the Thames Valley on World Suicide Prevention Day in September 2015 in a bid to prevent male suicide.

Thames Valley is the third CALMzone in the UK, following in the footsteps of Merseyside and London Tri-Borough area. A CALMzone is an area of the UK where CALM's helpline and campaign is actively promoted and callers to the helpline are signposted to local services in a variety of ways.

The West Berkshire Council Public Health Team are being supported by The Suicide Prevention and Intervention Network (SPIN) to promote CALM locally to local employers, sports clubs, along with music and comedy venues, to reach any men locally who may be down or in crisis. Research shows men are less likely to engage

with traditional help and health services and often feel stigmatised if they talk about what's going on in their lives.

CALM provides a free, confidential, and anonymous helpline for men. Their phone line and webchat provision is staffed by professionals who offer support, signposting and information to callers every day from 5pm to midnight.

The free telephone number is 0800 58 58 58, is free to call.

National and local strategies

Current national best practice includes:

- Department of Health (2012); Preventing Suicide in England: A cross-government outcomes strategy to save lives
- HM Government (2014); Preventing suicide in England: One year on
- HM Government (2015); Preventing suicide in England: Two years on
- Public Health England and Royal College of Nursing (2015); Preventing suicide among lesbian, gay and bisexual young people: A toolkit for nurses

Specific guidance emerging from updates to the national strategy include:

- The need for close working between specialist services, primary care, and credit counselling agencies to help local services support people with debt and mental health problems
- Local agencies to map what support is available within the local area for those affected or bereaved by a suicide and which agencies provide this support. There are also a number of local initiatives to move towards providing support for every family affected by suicide.
- GPs can make a big difference to overall suicide rates. People recover more quickly from depression if it is identified early and responded to promptly, using evidence-based treatment.
- Local services to develop systems for the early identification of children and young people with mental health problems in different settings, including schools.
- For Public Health Teams to work with other organisations to ensure services are joined up to respond to particular issues such as the recession, self-harm and to ensure information about depression and services is available in "male" settings

Public Health England will soon be publishing two further guidance documents for local areas. The first, on the prevention of suicides in public places will provide information on the practical steps local areas can take to reduce risks. The second, on responding to potential suicide clusters, will provide advice to local areas on practical steps to take in the event of multiple suicides, where a cluster effect is suspected.

Research and recommendations into the prevention and treatment of self harm:

- Young Minds and Cello (2012); Tackling self harm. Looks at self-harm symptoms, causes and interventions

- Royal College of Psychiatrists (2010); Self harm, suicide and risk. Provides background information, discusses results of survey and consultations with people working with young people who self harm, and makes a series of recommendations.

- Hawton and James, 2005: Suicide and deliberate self harm in young people. Provides background into the incidence and risk factors of deliberate self harm including suicide and make recommendations for the prevention, assessment, and treatment of self harm.

- Hamza, Stewart, and Willoughby (2012); Examining the link between non-suicidal self-injury and suicidal behaviour. Explores when and why self harm and suicidal behaviour are linked.

- Further links to self harm research and recommendations can be found in a briefing provided by the Association for Young People's Health (AYPH) and the National Child and Maternal Health Intelligence Network (2013).

Other chapters you might be interested in

Children and Adolescent Mental Health
Mental Health
Mental Health in Older Age
Substance Misuse

If you have any questions about this chapter, please contact Public Health and Wellbeing Team on publichealthandwellbeing@westberks.gov.uk or 01635 503437