Norfolk County Council

Public Health

Suicide and Injury Undetermined

2013

Summary

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1. Norfolk Suicide Prevention Strategy

The Norfolk Suicide Prevention Strategy sets out evidence and actions that local organisations and communities should use to focus their work in reducing suicides in Norfolk. It is structured around the goals of the National Suicide Prevention Strategy, taking account health and social care developments, recent updates on progress and evidence and views of local stakeholders.

Nationally, suicide rates are the lowest ever on record, but in Norfolk there is still room for improvement.

Actions identified are intended to reduce numbers of suicides by people who are currently or have recently been in contact with mental health services, numbers of suicides in the year following deliberate self-harm, reduce suicides among young men (who frequently do not choose to access services), among offenders and ex-offenders and among people in high-risk occupational groups.

Amongst the wider population, actions have been identified to promote the mental health of socially excluded, deprived and other vulnerable groups, among people from black and ethnic minority groups including Asian women, transgender, lesbian and gay people, people who misuse drugs and/or alcohol, victims and survivors of abuse, including child sexual abuse, children and young people, young women during and after pregnancy, older people and those bereaved by suicide.

To reduce access to the means, there are actions to reduce risks of hanging and strangulation, self-poisoning, use of railways and of firearms.

The importance of improving research evidence and sharing evidence is recognised and there must be a commitment to monitoring delivery of this strategy and crucially that suicide rates fall.

Whilst a three year strategy beyond the life of NHS Norfolk, it is anticipated that the Health and Wellbeing Board will ensure continuation of the work programme.

2. Aim

The aims of the Suicide and Injury Undetermined summary report are:

- To assess the number of suicides and deaths from undetermined injury, from 2003 to the 3rd of March 2011.

- To identify any important characteristics or trends in the events during this time.

- To reduce suicides in Norfolk by ensuring a coordinated approach to mental health promotion, treatment and care services whilst ensuring that services are relevant and appropriate to meet the varying degree of risk people may experience.

- To ensure that suicide prevention is seen as part of the broader public health population approach that spans the wider determinants of health, including employment, housing education and the environment as well as the specific needs of people identified at higher risk of suicide.

- To assess the number of suicides and deaths from undetermined injury, from 2003 to the 3rd of March 2011.

- To identify any important characteristics or trends in the events during this time.

3. Key findings:

3.1 Suicide and Injury Undetermined

- Data from the Office for National Statistics show deaths due to suicide or injury undetermined by year. Across Norfolk and Waveney between the years 2000 and 2010, the highest number, 107, occurred in 2004 and the lowest, 61, was seen in 2007. Over the 11 year period, the highest numbers of deaths from these causes were amongst residents of Great Yarmouth and Waveney with the least in the North Norfolk CCG area, and there were nearly 900 deaths in all. The long term trend has been a reducing rate, but this may have now reached a plateau.

- Through applying geo-demographic segmentation, it can be seen that just over half of these suicides took place among residents of isolated communities and nearly 40% among residents of 'small and midsized towns with strong local roots'.

- Numbers of suicides expected for the future, if trends don't change, have been predicted using data on mortality rates between 2006 and 2008. These have highest rates amongst males aged 35 - 64 followed by males aged 18 - 34, and lower rates for females aged 35 - 64, with young women aged 18 - 34 having the lowest rates of all.

4. What is next?

Further work should be undertaken, in collaboration with commissioners' eg

- Update the Suicide and Injury Undetermined strategy.
- Assess Suicide and Injury Undetermined statistics on annual basis.
- To measure how suicide affects others (ie partners, family, and relatives)?
- To assess the consequences of a failed suicide attempt.
- To identify other geographical areas with better outcomes in relation to their local population needs – exploring their local prevention strategies.

- To make recommendations on future data collections that will better inform future analysis.

5. Introduction

Suicide can be described as a fatal act of self-harm initiated with the intention of ending one's own life. Although often seen as impulsive, it may be associated with years of suicidal behaviour including suicidal ideation or acts of deliberate self-harm. Self-harm is defined as any act of self-poisoning or self-injury irrespective of motivation, and is associated with an increased risk of suicide.[1] [2]

The likelihood of a person committing suicide depends on several factors. These include physically disabling or painful illnesses and mental illness; alcohol and drug misuse; and level of support. Stressful life events such as the loss of a job, imprisonment, a death or divorce can also play a part. For many people, it is the combination of factors which is important, rather than any single factor.

There is no single or quick approach to suicide prevention. That is why nationally a broad strategic approach is encouraged which involves health and social care agencies, Government departments, and the voluntary and private sector organisations, communities, families and individuals.

[1] http://www.patient.co.uk/doctor/suicide-risk-assessment-and-threats-of-suicide
[2] Morriss R, Kapur N, Byng R; Assessing risk of suicide or self-harm in adults. BMJ. 2013 Jul 25;347:f4572. doi: 10.1136/bmj.f4572.

6. Epidemiology [3]

- In 2012, there were 5,981 suicides in the UK in people over the age of 15. This equates to 11.6 deaths per 100,000 of the population.
- Male suicides are three times as common. In 2012 in the UK there were 18.2 male deaths per 100,000 population, and 5.2 female deaths per 100,000.
- The highest suicide rate is in men aged 40-44. In this group there were 25.9 deaths per 100,000 population.
- Suicide rates in 2012 in the UK were higher than five years before, but lower than 20 years before. Suicides in the under-25 age group have significantly reduced in the last 20 years.
- The most common methods of suicide are hanging, strangulation and suffocation, followed by poisoning.
- Comparison of suicide rates between countries within and outside the UK is difficult due to differing definitions and age included in reported rates. In the UK, suicide rates are published for those over the age of 15.
- England, Wales, Scotland and Northern Ireland all have strategy policies in place for reducing the suicide rates.[4] [5] [6] [7]
- People with mental illness have a higher suicide risk than the general population.[8]
- A previous suicide attempt is the single biggest risk factor for suicide.[9] It is estimated that up to 50% of people who take their own lives have previously attempted to harm themselves.[10]

[3] Suicides in the UK. 2012 registrations; Office for National Statistics.
[4] Preventing suicide in England - A cross-government outcomes strategy to save lives; HM Government, 2012.
[5] Talk to me. The National action plan to reduce suicide and self harm in Wales 2009-2014; Welsh Assembly Government.
[6] Refreshing The National Strategy and Action Plan to Prevent Suicide in Scotland: Report of The National Suicide Prevention Working Group 2010; The Scottish Government.
[7] Protect Life: A shared vision. The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011; Department of Health, Social Services and Public Safety - Northern Ireland, 2006
[8] Windfuhr K, Kapur N; Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide. Br Med Bull. 2011;100:101-21. doi: 10.1093/bmb/ldr042. Epub 2011 Sep 22.
[9] Chang B, Gitlin D, Patel R; The depressed patient and suicidal patient in the emergency department: evidence-based management and treatment strategies. Emerg Med Pract. 2011 Sep;13(9):1-23; quiz 23-4.
[10] Welton RS; The management of suicidality: assessment and intervention. Psychiatry (Edgmont). 2007 May;4(5):24-34.

7. Risk factors for suicide

- Previous suicide attempt or previous self-harm.
- Male gender (three times more likely than women).
- Age - currently highest in the age group 40-44 years (In October 2014, there were **28,912** men aged 40-44 in Norfolk).
- Concurrent mental disorders or previous psychiatric treatment. (See 'Mental disorders and risk of suicide', overleaf)
- Unemployment.
- Homelessness
- Alcohol and drug abuse.
- Physically disabling or painful illness, including chronic pain.
- Low socio-economic status, loss of a job.
- Certain professions - this has changed in recent years. Historically, professions with the means/knowledge to kill themselves (vets, doctors, dentists, pharmacists, farmers) had the highest rates of suicide. More recently, rates in these professions have reduced significantly (although remaining comparatively high) and higher numbers are seen amongst manual occupations such as construction workers and plant/machine operatives.[11] [12].
- Low social support/living alone.
- Significant life events - bereavement, family breakdown.
- Institutionalised - eg, prisons, army.
- Bullying (sometimes a factor in children and adolescents where social media and/or pro-suicide websites play a part).

[11] Meltzer H, Griffiths C, Brock A, et al; Patterns of suicide by occupation in England and Wales: 2001-2005. Br J Psychiatry. 2008 Jul;193(1):73-6. doi: 10.1192/bjp.bp.107.040550.
[12] Roberts SE, Jaremin B, Lloyd K; High-risk occupations for suicide. Psychol Med. 2013 Jun;43(6):1231-40. doi: 10.1017/S0033291712002024. Epub 2012 Oct 26.

8. Mental disorders and risk of suicide[13]

The risk of suicide in patients with mental disorders is 5-15 times higher than that for patients without co-existent mental disorders. Around 90% of individuals who die by suicide have mental illness, although this varies globally. Around 25% in the UK have been in contact with mental health services prior to death. Risk is thought to be greatly increased following discharge from inpatient mental health wards, although inpatient suicides have reduced significantly over a period of 20 years.

In the UK the most common diagnoses among those dying from suicide are:

- Affective disorders (32-47%) particularly depression (see **Table 1** for local depression prevalence among people aged 18+).
- Schizophrenia (15-20%).
- Alcohol dependence (8-17%).
- Personality disorder (8-11%).
- Drug dependence (3-9%).

The level of risk varies in different disorders. For example, studies suggest that patients with schizophrenia have an 8.5-fold greater risk of suicide than the general population.[14]

Suicidal ideation and behaviour, however, may occur in the absence of mental health disorders. One UK household survey showed 17% of the general population have had suicidal thoughts in their lifetime.[15]

[13] Windfuhr K, Kapur N; Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide. Br Med Bull. 2011;100:101-21. doi: 10.1093/bmb/ldr042. Epub 2011 Sep 22.
[14] Kasckow J, Felmet K, Zisook S; Managing suicide risk in patients with schizophrenia. CNS Drugs. 2011 Feb;25(2):129-43. doi: 10.2165/11586450-000000000-00000.
[15] Mental health facts and statistics; MIND, 2012.

Table 1: GP practice disease registry prevalence for people aged 18+ with depression in Norfolk and Waveney by CCG, 2012/13 and 2013/14

CCG	No of practices	2012-13			2013-14		
		Estimated List Size 18+	Register	Prevalence (per cent)	Estimated List Size 18+	Register	Prevalence (per cent)
GY&W	27	187,695	12,576	6.70	189,042	14,129	7.47
North	20	140,087	6,681	4.77	140,237	8,007	5.71
Norwich	24	168,640	9,252	5.49	173,398	10,649	6.14
South	25	179,489	10,763	6.00	182,754	11,918	6.52
West	23	135,512	7,848	5.79	136,593	8,912	6.52
Norfolk & Waveney	**119**	**811,422**	**47,120**	**5.81**	**822,025**	**53,615**	**6.52**

Note: *GY&W = Great Yarmouth and Waveney CCG (It is also called Health East CCG)*

9. Assessment

Assessing the risk of suicide in a person expressing suicidal thoughts, or presenting with self-harm or a suicide attempt is crucial in attempting to prevent deaths. There are a number of risk-predicting score systems for determining suicidal intent. However, none have good predictive ability, and National Institute for Health and Care Excellence (NICE) guidelines advise these should NOT be used.[16] Instead a comprehensive clinical interview should be used for assessment as follows:

9.1 General

- Establish rapport, develop a trusting relationship.
- Use open questions.
- Establish current anxieties or problems.

9.2 Assess risk factors

- Assessment of mental health:
  - Past psychiatric history.
  - Depressive and other psychiatric symptoms.
  - Medication.
  - History of alcohol and illicit drug use.
  - Observe verbal and non-verbal indicators of mental state (eye contact, apparent mood, hallucinations and unusual beliefs, agitation, speed of speech).
- Previous self-harm or suicide attempts.
- Age, gender, social situation.
- Relationships which may be supportive / protective, or which may pose a threat (abuse or neglect).
- Access to lethal methods.

9.3 Assess current intent and plans

- Wish to be dead.
- Feelings of hopelessness.
- Regret/remorse over current/previous attempt.
- Expectation about outcome of self-harming behaviour or suicide attempt/threat.
- Specific plans.
- Lethality and frequency of plans or attempts.
- Other self-harming behaviour.
- Assess current suicidal intent/wishes.
- Length of time suicidal feelings have been present.
- Mental state at time of self-harm or suicide attempt or threat (alcohol or drug intake, social situation, relationship changes, bereavements).

[16] Self-harm (longer-term management); NICE Clinical Guideline (November 2011)

- Plans for others after death: suicide notes, changes to will, consequences.

9.4 Assess needs[17]

- Social problems.
- Untreated mental health disorders.
- Physical symptoms and disorders.
- Coping strategies.
- Skills, strengths and assets.
- Psychosocial and occupational functioning.
- Personal and financial difficulties.
- Needs of dependents.

[17] Self-harm (longer-term management); NICE Clinical Guideline (November 2011)

10 Management

10.1 General

- Following assessment as above, form a summary and a risk assessment. There will be a balance of risk and protective factors, which will vary between individuals and which may further vary between situations in any one individual (for example, after consumption of alcohol, with fluctuating moods in mental disorders, or with changing life events). It is inevitably not entirely precise or predictable. However, accurate assessment followed by appropriate support and treatment may save lives.
- Subsequent action will depend on the level of risk believed to be present. It will also be guided by specific risk factors identified.
- Aim to be supportive, empathetic and reassuring in developing a relationship.
- Remove access to preferred means of suicide where possible.

10.2 Care plans

Form and agree a care plan. Aims may include:

- Prevent self-harm or suicide attempts, or escalation of either behaviour.
- Reduce level of injury from self-harming behaviour.
- Improve quality of life.
- Improve social or occupational functioning.
- Improve mental health conditions.
- Improve physical symptoms.

10.2.1 Care plans should:

- Be multidisciplinary (and be shared with the person's GP if not involved).
- Be developed collaboratively with the person who has self-harming or suicidal behaviour.
- Identify short- and long-term goals, steps to achieve them, and professionals responsible for helping achieve them.
- Include a risk management plan:
    - Address specific identified risk factors where these can be modified.
    - Include a crisis plan (self-management strategies, and how to access services in a crisis).

10.2.2 Specific treatment options may include:

- Medication.
- Counselling.
- Cognitive behavioural therapy (CBT).
- Dialectical behaviour therapy (DBT) - a specific type of CBT which has the largest evidence base, although more studies are needed to establish the most effective psychological therapy.[18] DBT focuses on acceptance techniques, and change techniques, helping people change damaging patterns of behaviour.

Provide follow-up at regular intervals, depending on assessed level of risk, but probably within 24 hours.

10.3 Management of high-risk individuals

If high level of risk is established, it is vital to ensure safety with 24-hour support through the crisis team of the local mental health service. Consider grounds for psychiatric evaluation and detention under the Mental Health Act if the person refuses.

[18] Chesin M, Stanley B; Risk assessment and psychosocial interventions for suicidal patients. Bipolar Disord. 2013 Aug;15(5):584-93. doi: 10.1111/bdi.12092. Epub 2013 Jun 20.

11. Priorities of the National Suicide Prevention Strategy

These fully reflect the goals of the National Suicide Prevention Strategy and are as follows:

- Reduce risk and therefore number of suicides in key high risk groups, namely prisoners, people who are currently or have been in contact with mental health services within the last year, people in the year following deliberate self-harm, high risk occupational groups and young men.

- Promote mental wellbeing in the wider population, recognising the negative impact of the economic downturn affecting debt, work, housing and other social factors, plus the health and care needs of people, particularly older people who may have depression, long term illness or be bereaved. Within the wider population, special consideration will be given to the needs of socially excluded and deprived groups, black and ethnic minority groups including Asian women, lesbian, gay and transgender people.

- Reduce availability and lethality of suicide methods, particularly hanging and strangling, self-poisoning, motor vehicle exhaust gas, railways, places to jump from and firearms.

- Monitoring improved reporting of suicide behaviour in the media.

- Promote research on suicide and suicide prevention.

- Monitor progress to reduce the number of suicides.

12. Suicide and injury undetermined

12.1 Suicide and injury undetermined trends for Norfolk and Waveney

Suicide and injury undetermined defined based on International Classification of Disease as follows: ICD9 E950-E959, E980-E989 excluding E988.8; ICD10 X60-X84, Y10-Y34 excluding Y33.9.

Deaths which may be suicide require an inquest from the Coroner. The Coroner requires proof beyond reasonable doubt of the intention to end life in order to reach a suicide verdict. This can be difficult and a verdict may be given instead as an 'open verdict'. Therefore, the Office for National Statistics (ONS) routinely includes open verdicts in deaths from suicide and injury undetermined within its definition of suicide. For this reason there can be substantial discrepancies between the Public Health Mortality File (PHMF) produced by the ONS for the number of deaths resulting from suicide or undetermined injury and the figures from the Coroner's Office for the local suicide audit.[19]

Trends in suicide or death from injury undetermined at a national level were reviewed by the Department of Health in 2012 to inform the latest suicide prevention strategy for England. The publication was accompanied by a statistic update.[20]

ONS data on suicide and injury undetermined, 2000-2010 by local authority is shown on **Table 2**. Figures below five are not shown for confidentiality reasons. Due to the high number of males relative to females, data by gender likewise are not shown.

The highest number of deaths attributed to suicide and injury undetermined was seen in 2004 (107 deaths) and lowest in 2007 (61), consistent with the national trend. There were 70 deaths in Norfolk and Waveney in 2010, the most recent year where data was published.

[19] Local internal audit is required to assess such differences.
[20] https://www.wp.dh.gov.uk/health/files/2012/09/Statistical-update-on-suicide.pdf

Table 2: Deaths from suicide and injury undetermined by local authority for Norfolk and Waveney, 2000-2010

Local authority	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Breckland	10	13	14	14	12	10	16	11	7	8	6
Broadland	11	6	9	8	15	12	<5	<5	14	10	<5
Great Yarmouth	5	6	6	5	10	8	<5	<5	5	16	9
KL&WN	12	20	12	15	18	14	16	9	18	5	14
North Norfolk	9	10	10	11	8	8	6	<5	8	5	<5
Norwich	13	12	11	14	15	13	12	13	16	13	16
South Norfolk	11	9	12	6	13	9	8	12	12	8	12
Waveney	14	10	17	5	16	8	10	16	15	11	6
Norfolk	**71**	**76**	**74**	**73**	**91**	**74**	**66**	**52**	**80**	**65**	**64**
Norfolk and Waveney	**85**	**86**	**91**	**78**	**107**	**82**	**68**	**61**	**95**	**76**	**70**

Data source: *Office for National Statistics (**ONS**), Published at Information Centre (**IC**)*

Table 3 shows the mortality figures for suicide and injury undetermined for 2003-2011 by Clinical Commissioning Group. This data was obtained from the Primary Care Mortality Database (**PCMD**), based on registration with a GP rather than place of residence and this explains the small differences to the data shown on **Table 2**.

The average figures of deaths from suicide and injury undetermined over the time period vary from 13 per year in West Norfolk CCG to 19 in Great Yarmouth and Waveney CCG.

Table 3: Total number of deaths from suicide and injury undetermined by CCG for Norfolk and Waveney, 2003-2011

	GY&W	North	Norwich	South	West	Missing	Norfolk and Waveney
2003	13	15	20	14	12	7	81
2004	26	15	24	23	18	5	111
2005	20	15	17	19	17	4	92
2006	20	6	17	14	14	5	76
2007	18	9	18	18	15	4	82
2008	18	9	20	12	11	8	78
2009	15	10	18	13	7	6	69
2010	20	5	14	15	14	2	70
2011	19	8	16	19	13	0	75
Total (2003-2011)	**169**	**92**	**164**	**147**	**121**	**41**	**734**
Average per year	**19**	**10**	**18**	**16**	**13**	**5**	**82**

Note: *Data source Primary Care Mortality Database (**PCMD**)*

Table 4 gives the combined number and percentage mortality from suicide and injury undetermined by age group for 2003-2011 by age group and gender. The highest figures for males is seen for those aged 35-54 years and those aged 75 years or more, while the highest figures were seen for females aged 50-59 and those aged 75 years or more.

Table 4: Total number of deaths from suicide and injury undetermined by age band for Norfolk and Waveney, 2003-2011

Age band	Numbers			%		
	Males	Females	Persons	Males	Females	Persons
10-19			13			1.8
20-24	29	7	36	5.4	3.8	4.9
25-29	36	13	49	6.7	7.1	6.7
30-34	35	14	49	6.5	7.7	6.7
35-39	60	12	72	11.2	6.6	9.8
40-44	70	17	87	13.0	9.3	11.9
45-49	64	13	77	11.9	7.1	10.5
50-54	60	28	88	11.2	15.3	12.0
55-59	58	17	75	10.8	9.3	10.2
60-64	31	14	45	5.8	7.7	6.1
65-69	25	13	38	4.6	7.1	5.2
70-74	12	11	23	2.2	6.0	3.1
75+	58	24	82	10.8	13.1	11.2
Total	**538**	**183**	**734**			

12.2 Suicide and injury undetermined by MOSAIC social group

MOSAIC is a geo-demographic segmentation system developed by Experian and marketed in over twenty countries worldwide. Each of the nearly one-quarter million block groups was classified into sixty segments on the basis of a wide range of demographic characteristics. The basic premise of geo-demographic segmentation is that people tend to gravitate towards communities with other people of similar backgrounds, interests, and means. MOSAIC is linked to the systems in other nations through the Global MOSAIC classification, which consists of fourteen market segments found in every modernised country. A number of geo-demographic segmentation tools are available; of which Norfolk County Council currently hold a licence for the MOSAIC software, from which MOSAIC and Health MOSAIC classifications may be produced. **Table 5** shows the social backgrounds for those who had mortality from suicide and injury undetermined for 2003-2011 after applying applied the PCMD mortality to MOSIAC. There were 396 (54%) person residents of isolated rural communities, 279 (38%) Residents of small and mid-sized towns with strong local roots, 36 (4.9%) Young, well-educated city dwellers, and 7 (1%) Wealthy people living in the most sought after neighbourhoods who committed suicide or had undetermined injury.

Table 5: Total number and percentage of deaths from suicide and injury undetermined by Mosaic Geo-demographic segmentation (social characteristics) within Norfolk and Waveney, 2003-11

MOSAIC group	number	%
A Residents of isolated rural communities	396	54.0
B Residents of small and mid-sized towns with strong local roots	279	38.0
C Wealthy people living in the most sought after neighbourhoods	7	1.0
G Young, well-educated city dwellers	36	4.9
Missing	16	2.2
Total	**734**	

Table 6 and **Figure 1** provide the age specific mortality rates from suicide and injury undetermined per 100,000 persons for 2000-2002 to 2008-10 (Pooled as three years rolling average).[21] Overall the rates are lower in Norfolk compared to East of England and England average rates for females but not for males who had lower rates than England but higher rates than East of England. For Norfolk, there has been a decline in the rates over the entire period of time for males and females. However there were small rises during 2000-02 and 2004-06 for both males and females.

[21] Data source is Information Centre (**IC**)

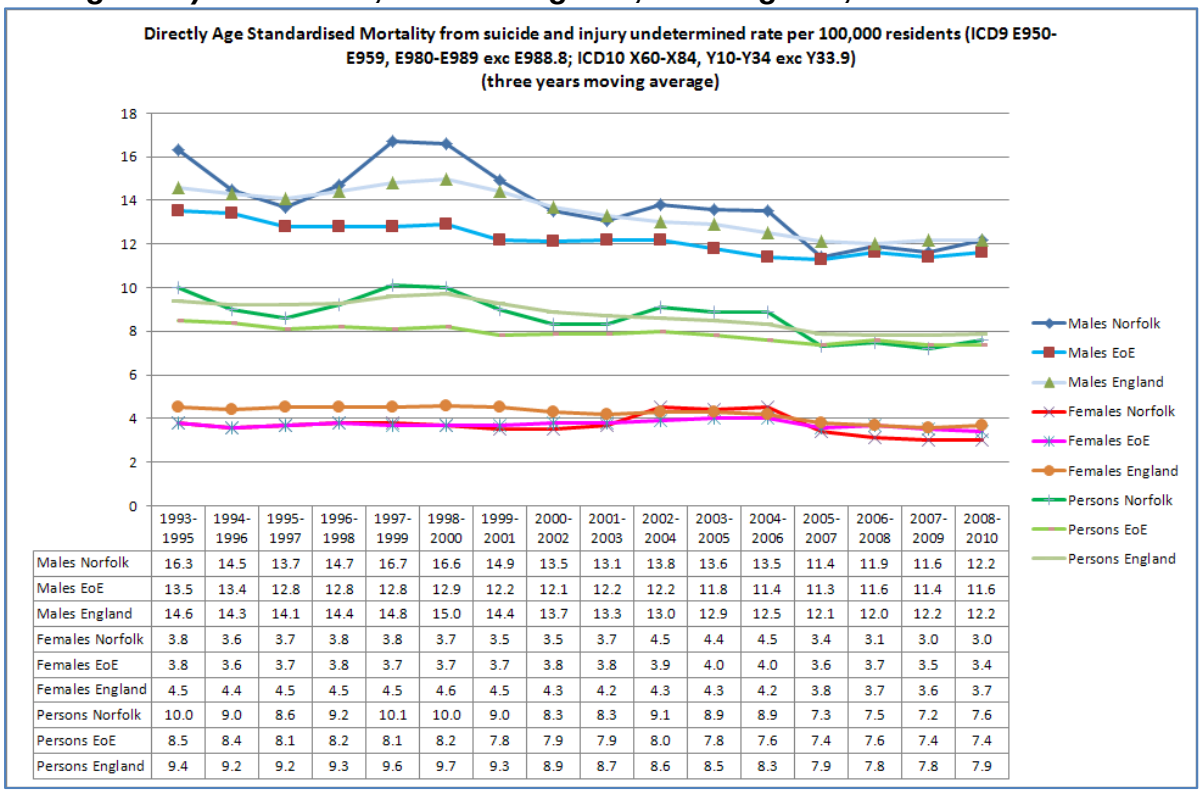
Table 6: All ages, directly age-standardised mortality rates (DSR) for suicide and injury undetermined mortality per 100,000 persons (three years rolling average rate) for Norfolk, East of England, and England, 2000-2010

Gender	Area	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Males	Norfolk	13.5	13.1	13.8	13.6	13.5	11.4	11.9	11.6	12.2
	EoE	12.1	12.2	12.2	11.8	11.4	11.3	11.6	11.4	11.6
	England	13.7	13.3	13.0	12.9	12.5	12.1	12.0	12.2	12.2
Females	Norfolk	3.5	3.7	4.5	4.4	4.5	3.4	3.1	3.0	3.0
	EoE	3.8	3.8	3.9	4.0	4.0	3.6	3.7	3.5	3.4
	England	4.3	4.2	4.3	4.3	4.2	3.8	3.7	3.6	3.7
Persons	Norfolk	8.3	8.3	9.1	8.9	8.9	7.3	7.5	7.2	7.6
	EoE	7.9	7.9	8.0	7.8	7.6	7.4	7.6	7.4	7.4
	England	8.9	8.7	8.6	8.5	8.3	7.9	7.8	7.8	7.9

Note: *Data source is Office for National Statistics (**ONS**), Published at Information Centre (**IC**)*

Note: *Data for Norfolk and Waveney is not published as combined data.*

Figure 1: All ages, directly age-standardised mortality rates (DSR) for suicide and injury undetermined mortality per 100,000 persons (three years rolling average rate) for Norfolk, East of England, and England, 2000-2010



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Males Norfolk	16.3	14.5	13.7	14.7	16.7	16.6	14.9	13.5	13.1	13.8	13.6	13.5	11.4	11.9	11.6	12.2
Males EoE	13.5	13.4	12.8	12.8	12.8	12.9	12.2	12.1	12.2	12.2	11.8	11.4	11.3	11.6	11.4	11.6
Males England	14.6	14.3	14.1	14.4	14.8	15.0	14.4	13.7	13.3	13.0	12.9	12.5	12.1	12.0	12.2	12.2
Females Norfolk	3.8	3.6	3.7	3.8	3.8	3.7	3.5	3.5	3.7	4.5	4.4	4.5	3.4	3.1	3.0	3.0
Females EoE	3.8	3.6	3.7	3.8	3.7	3.7	3.7	3.8	3.8	3.9	4.0	4.0	3.6	3.7	3.5	3.4
Females England	4.5	4.4	4.5	4.5	4.5	4.6	4.5	4.3	4.2	4.3	4.3	4.2	3.8	3.7	3.6	3.7
Persons Norfolk	10.0	9.0	8.6	9.2	10.1	10.0	9.0	8.3	8.3	9.1	8.9	8.9	7.3	7.5	7.2	7.6
Persons EoE	8.5	8.4	8.1	8.2	8.1	8.2	7.8	7.9	7.9	8.0	7.8	7.6	7.4	7.6	7.4	7.4
Persons England	9.4	9.2	9.2	9.3	9.6	9.7	9.3	8.9	8.7	8.6	8.5	8.3	7.9	7.8	7.8	7.9

12.3 Suicide projected estimate, 2012-2030

Projecting Adult Needs and Service Information (PANSI) calculated the estimated projected number of persons committing suicide 2012-2030. PANSI based these estimate on information contained in the Clinical and Health Outcomes Knowledge Base, a source of information on health outcomes generated by NCHOD (the National Centre for Health Outcomes Development).[22] The database provides mortalities from suicide per 100,000 populations by Government Office Region and for England. This information is derived from Office for National Statistics data (ONS). The prevalence rates were then applied to ONS population projections for the 18-64 population to give estimated numbers of mortalities from suicide, projected to 2030, assuming that rates do not change.

Table 7 shows mortality rates from suicide for males and females aged 18 to 34 and 35 to 64 by region per 100,000 between 2006 and 2008.

Table 7: National regional Mortality rates per 100,000 from suicide for males and females aged 18 to 34 and 35 to 64, 2006-2008

	Males		Females	
	18-34	**35-64**	**18-34**	**35-64**
England	8.9	14.0	2.3	3.9
North East	9.6	15.0	1.8	3.8
North West	11.6	17.2	2.4	4.0
Yorkshire and the Humber	10.6	15.7	2.0	4.0
East Midlands	9.3	13.6	2.4	3.9
West Midlands	8.8	13.3	2.2	3.3
East	**9.1**	**12.6**	**2.3**	**4.1**
London	6.1	10.7	2.4	3.2
South East	8.2	13.3	2.2	4.3
South West	8.9	15.6	2.5	3.8

Table 8 shows The East of England rate applied to local population data on Norfolk and Waveney, projected to 2030. Figures at local authority level are given in **Appendix F**.

Table 8: Estimated number of deaths from suicide for males and females aged 18 to 34 and 35 to 64 (if the suicide rates do not change) for Norfolk and Waveney, 2012-2030

Norfolk and Waveney	**2012**	**2015**	**2020**	**2025**	**2030**
Males aged 18-34 predicted to commit suicide	9	9	9	9	9
Males aged 35-64 predicted to commit suicide	24	24	24	25	25
Females aged 18-34 predicted to commit suicide	2	2	2	2	2
Females aged 35-64 predicted to commit suicide	8	8	8	8	8
Total population aged 18-64 predicted to commit suicide	**43**	**43**	**43**	**44**	**45**

[22] This data used to be provided at NCHOD database (the National Centre for Health Outcomes Development), http://www.nchod.nhs.uk/. The information centre (IC) holds this data currently.

13. National Suicide Prevention Strategy Goals and Actions

13.1 Goal 1: To reduce risk and therefore suicides in high risk groups

13.1.1 Reduce the number of suicides by people who are currently or have recently been in contact with mental health services

- All mental health clinical staff, plus key staffing - A&E, Ambulance, police, social services, prison – who are in contact with patients at risk of self-harm or suicide receive training in the recognition, assessment and management of risk at intervals of no more than 3 years.
- Known mental health patients at risk of suicide have their risks assessed, recorded and where appropriate, plans are made to mitigate against their risks in conjunction with the patient.
- People with severe mental illness, if in contact with the criminal justice system have clear pathways for assessment of needs that to include hospital provision if appropriate.
- Atypical anti-psychotics prescribed and dispensed according to national guidelines (NICE), and monitoring of antipsychotics prescriptions via regular audit cycles.
- Clinical areas in mental health, acute and prison settings conform to national safety and regulatory bodies' guidance, with appropriate monitoring.
- Therapeutic aspects of care in mental healthcare trusts have a service user focus and involve multidisciplinary teams and other community support services including voluntary and non-statutory services.
- Audit of suicides of people known to the mental health service to inform strategy (mental health trust, prison and community) updates.
- Ensure accessible primary mental healthcare services including to psychological therapies.

13.1.2 Reduce the number of suicides in the year following deliberate self-harm

- NICE self-harm guidance should continue to apply to acute, mental healthcare and ambulance trusts, ensuring all staff and others as appropriate have training on self-harm, using operational protocols.
- There is specific training and protocols for children and young people's services.
- There is closer working between acute and mental healthcare trusts, to continuously improve patient pathways.
- There is support to encourage near miss incident reporting
- Arrangements for discharge from the mental health trust are based on current evidence for best practice, involving effective work with community sector.

13.1.3 Reduce the number of suicides by young men

- Strengthen existing networks that connect with young men and raise awareness of issues using information from recognised sources.
- Local partnerships to promote wellbeing amongst young men particularly in rural areas and in areas of social disadvantage.

13.1.4 Reduce the number of suicides by offenders or ex-offenders

- There is suitable planning for release from police custody if the person is a known self-harmer or a cause of concern.
- Where a person is known by the prison service to be suicidal and sent to court, liaison will be arranged if there is a possibility of release on bail.
- Prison officers and healthcare staff have mental health awareness training.
- Where a person is transferred into prison from any hospital setting, there is appropriate information sharing arrangements.
- Reception screening for mental health problems is in place, including risk management and opportunities for intervention.
- Central role for primary care mental health team to ensure mental health pathway is embedded across the prison.
- There are good quality Integrated Drug Treatment Services
- Discharge planning follows an 'enhanced discharge process', including use of hand held medical records and consideration of informing for example emergency hostels, community liaison, Samaritans etc.

13.1.5 Reduce the number of suicides by high-risk occupational groups

- All statutory organisations have mental health at work policies.
- Health and Wellbeing Board promotes positive mental health throughout policies and encourages small businesses to have mental health at work policies.
- Links between suicide prevention group and organisations representing high risk occupational groups such as healthcare professionals, vets, farming communities.

13.2 Goal 2: To promote mental wellbeing in the wider population

13.2.1 Promote mental health among children and young people (aged under 18 years)

- Health and Wellbeing Board ensures mental and emotional wellbeing of children and young people is included in mental health promotion strategy
- Good practice guidance is followed for schools, early years and looked after children
- Support for young people is available, e.g. use of mobile phones, safer internet training (by police) for schools
- CAMHS services continue to develop their mental health promotion functions
- Priority is given to young adults with complex needs

13.2.2 Promote the mental health of socially excluded, deprived and other vulnerable groups

- Continue to improve access to psychological therapies and pathways to other primary care mental health services
- Local mental health services target specialised continue support to homeless people and those in temporary accommodation
- The Health and Wellbeing Board ensures robust strategy to prioritise mental health needs of social excluded, deprived and other vulnerable groups
- Health Trainer services ensure staff trained in mental health awareness and promote mental health for their client groups, particularly those in rural areas

13.2.3 Promote mental health among people from black and ethnic minority groups, including Asian women, and transgender, lesbian and gay people

- Suicide awareness training for clinical staff working with these groups
- Ensure equality impact assessments are carried out within statutory and third sector organisations, that race equality and diversity schemes are operated and that there is reporting at Board level.
- Voluntary and community groups are involved in planning and evaluation of services, e.g. Norwich Asylum Seekers Refugee Forum.

13.2.4 Promote the mental health of people who misuse drugs and or alcohol, plus that of their families and carers

- Suicide awareness training for staff caring for people at risk
- Information and sources of help are available
- Care pathways for patients with dual diagnosis are consistent, irrespective of the point of entry into care, i.e. via drug and alcohol services or mental health trust.
- Health and Wellbeing Board works towards promoting responsible alcohol use and local communities are actively involved in promoting mental health of people who abuse drugs and/or alcohol

13.2.5 Promote the mental health of victims and survivors of abuse, including child sexual abuse

- Promote and evaluate the police and health service Sexual Assault Referral Centre that works in collaboration with voluntary and statutory organisations.
- Health and wellbeing Board to promote partnership work with the community sector to provide suitable specialist services such as crisis centres, refuges, self-help groups etc.
- Work to address domestic violence is evaluated for effectiveness.

13.2.6 Promote mental health among young women during and after pregnancy

- Maternity services operating to best practice standards , including screening, identification and early intervention for young mothers at risk of mental health problems during and after pregnancy
- Health and Wellbeing Board promotes multiagency strategy for improving mental and emotional wellbeing of young women during and after pregnancy, as part of overall health and wellbeing strategy

13.2.7 Promote mental health among older people

- Best practice standards in primary care for bereavement, social isolation, loneliness, dementia, depression and suicide risk
- Ensure availability of good information on services
- Local partnerships promote Integrated local support for older adults, including keeping active, maintaining social contact and contributions to local communities
- Raise awareness of risks with managers of sheltered housing

13.2.8 Promote the mental health of those bereaved by suicide

- Ensure information and support is available for families, especially parents, and carers (e.g. Help is at Hand, local self-help groups).
- Mechanisms in place to ensure support for children who are bereaved.

13.3 Goal 3: Reduce access to the methods

13.3.1 Reduce the number of suicides as a result of hanging and strangulation

- Regular audits of safety precautions in prisons, mental health trust and other acute health settings including A&E and accident wards

13.3.2 Reduce the numbers of suicides as a result of self-poisoning

- Safer prescribing protocols are adhered to and monitored
- Liaise with pharmacy advisers for appropriate information distribution

13.3.3 Reduce the number of suicides on railways

- Local suicide audit does special collection of suicide and suicide attempts on the railway network to ascertain any opportunities for prevention
- Include transport police in Norfolk suicide stakeholder group

13.3.4 Reduce the number of suicides using firearms

- Local suicide audit does special collection to detect use of firearms and monitor patterns and high risk groups.

13.4 Goal 4: improve media reporting of suicide

13.4.1 Promote responsible representation of suicidal behaviour in the media

- Communications network (health and social care) within Norfolk adopting and promoting best practice guidance.

13.5 Goal 5: Promote research on suicide prevention

13.5.1 Improve research evidence on suicide prevention

- Identify and invite academic research lead to Norfolk suicide prevention stakeholder group
- Maintain and further develop the NHS N database that anonymously links SUI information from mental health trusts, prisons and community suicide audit information
- Conduct qualitative local studies to capture information to develop the local evidence base, e.g. railway associated and near misses
- Involve users of services and teams providing services to collect local data and information on uncompleted suicides and recovery (acute trust A&E departments)

13.5.2 Disseminate evidence on suicide prevention

- Use the local press to share up to date information on suicide prevention with general public, e.g. information on services, phone lines and good practice
- Work with communications departments of mental health trust and statutory organisations to ensure and co-ordinate availability of public information through leaflets, campaigns, websites etc.
- Keep up to date with local regional national and international developments in suicide prevention through suicide prevention stakeholders group

13.6 Goal 6: Improve monitoring of progress

13.6.1 Suicide statistics relevant to goals:

- develop suicide audit to incorporate information on police data on attempted suicides, trend data (3 year averages) by gender, age, ethnicity, method, location etc., and separate analysis from local prisons on self-harm and suicide

13.6.2 Evaluate local suicide prevention strategy

- Develop clear mechanisms, e.g. CQUINs for monitoring actions
- Develop monitoring for updating strategy progress
- Written annual report on progress, with recommendations to the Mental Health Delivery Unit of NHS Norfolk

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- Dazzi T, Gribble R, Wessely S, et al; Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? Psychol Med. 2014 Jul 7:1-3.

- Self-harm, suicide and risk: helping people who self-harm; Royal College of Psychiatrists, 2010.

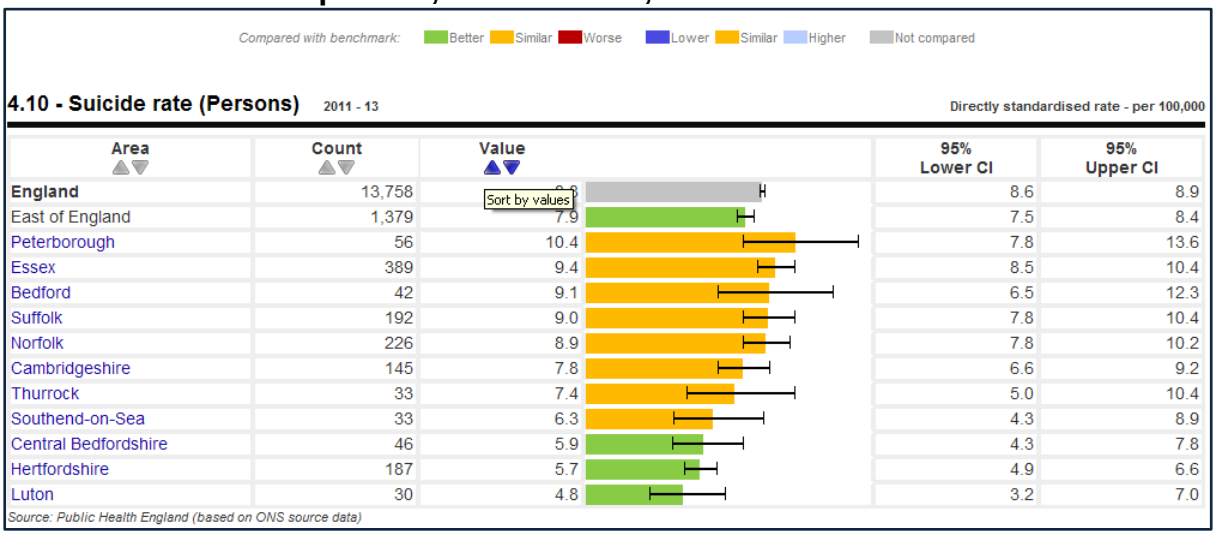
- Wasserman D, Rihmer Z, Rujescu D, et al; The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. Eur Psychiatry. 2012 Feb;27(2):129-41. doi: 10.1016/j.eurpsy.2011.06.003. Epub 2011 Dec 1.

- Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care; NICE Clinical Guideline (2004).

Appendices

Appendix 1: Public Health Outcomes Framework (Healthcare and premature mortality)

All persons Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 residents, 2011-13



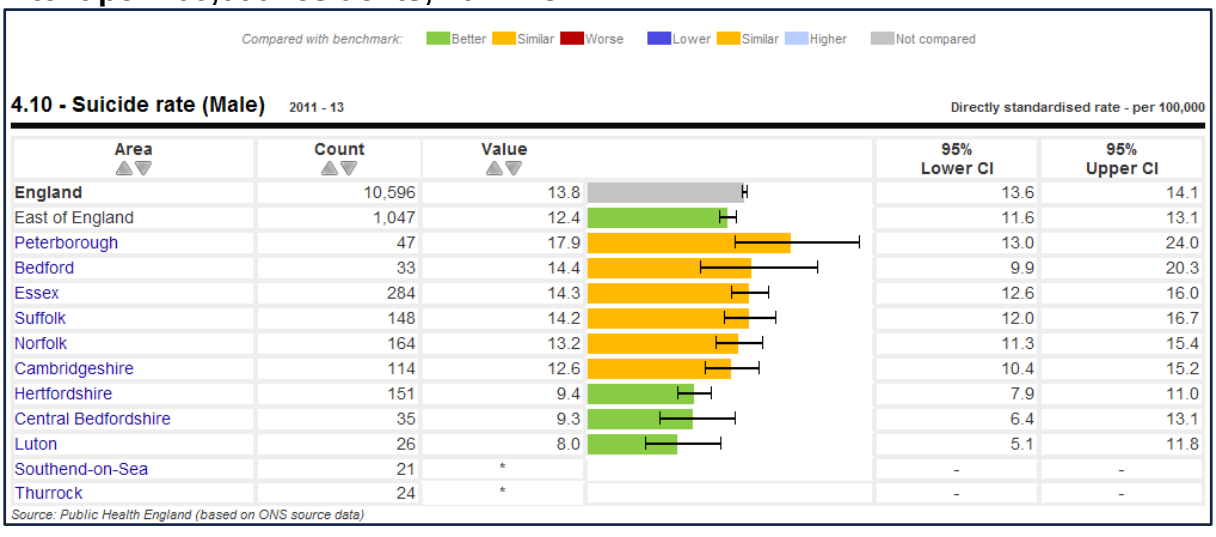
4.10 - Suicide rate (Persons) 2011 - 13 — Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	13,758	[illegible]	8.6	8.9
East of England	1,379	7.9	7.5	8.4
Peterborough	56	10.4	7.8	13.6
Essex	389	9.4	8.5	10.4
Bedford	42	9.1	6.5	12.3
Suffolk	192	9.0	7.8	10.4
Norfolk	226	8.9	7.8	10.2
Cambridgeshire	145	7.8	6.6	9.2
Thurrock	33	7.4	5.0	10.4
Southend-on-Sea	33	6.3	4.3	8.9
Central Bedfordshire	46	5.9	4.3	7.8
Hertfordshire	187	5.7	4.9	6.6
Luton	30	4.8	3.2	7.0

Sort by values

Source: Public Health England (based on ONS source data)

Males Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 residents, 2011-13

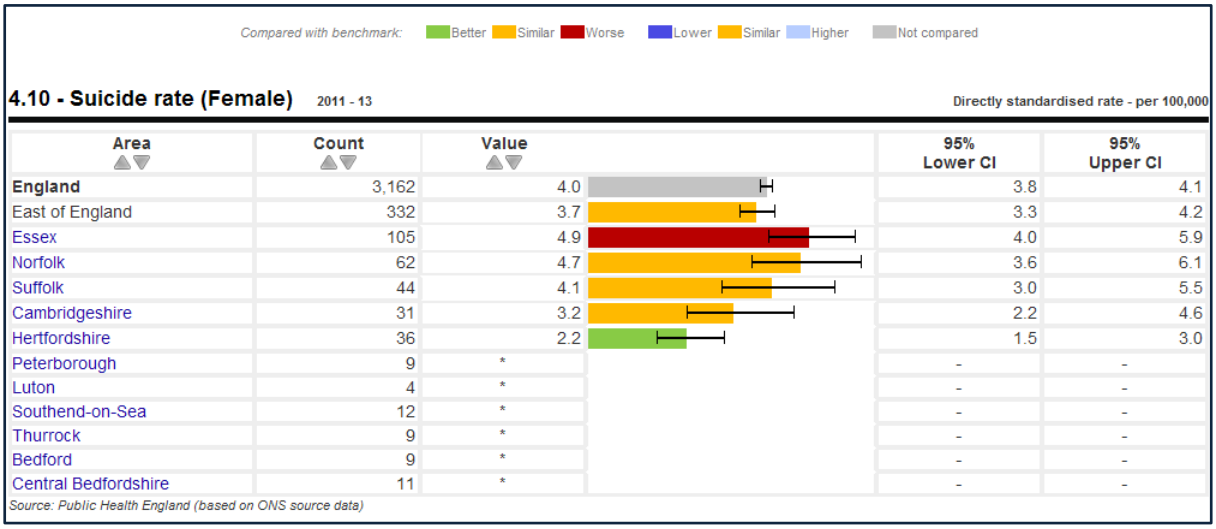


4.10 - Suicide rate (Male) 2011 - 13 — Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	10,596	13.8	13.6	14.1
East of England	1,047	12.4	11.6	13.1
Peterborough	47	17.9	13.0	24.0
Bedford	33	14.4	9.9	20.3
Essex	284	14.3	12.6	16.0
Suffolk	148	14.2	12.0	16.7
Norfolk	164	13.2	11.3	15.4
Cambridgeshire	114	12.6	10.4	15.2
Hertfordshire	151	9.4	7.9	11.0
Central Bedfordshire	35	9.3	6.4	13.1
Luton	26	8.0	5.1	11.8
Southend-on-Sea	21	*	-	-
Thurrock	24	*	-	-

Source: Public Health England (based on ONS source data)

Females Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 residents, 2011-13



4.10 - Suicide rate (Female) 2011 - 13

Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	3,162	4.0	3.8	4.1
East of England	332	3.7	3.3	4.2
Essex	105	4.9	4.0	5.9
Norfolk	62	4.7	3.6	6.1
Suffolk	44	4.1	3.0	5.5
Cambridgeshire	31	3.2	2.2	4.6
Hertfordshire	36	2.2	1.5	3.0
Peterborough	9	*	-	-
Luton	4	*	-	-
Southend-on-Sea	12	*	-	-
Thurrock	9	*	-	-
Bedford	9	*	-	-
Central Bedfordshire	11	*	-	-

Source: Public Health England (based on ONS source data)

Appendix 2: How suicide affects others

There is no blueprint for how we react to and cope after a suicide. We each have our own relationship with the person who died and we all grieve in our own way and at our own pace.[23]

When someone grieves in a different way to you, it doesn't mean that they don't care – they are just finding their own way to cope. But it can be hard if they behave in a way that you can't relate to. It can also be difficult to express our own grief around others if they are reacting differently, especially if those people also had a close relationship with the person who died.

Patience and understanding is helpful and it important that you try and find somewhere you can share your feelings. And remember that there is support available from others from outside friends and family – this can provide a space to "be yourself" without having to worry about how others will react.

Read on to find out more about suicide bereavement can affect:

- Partners.
- Siblings.
- Sons and daughters.
- Grandparents.
- Extended family.
- Ex partners.
- Friends and colleagues.
- Clients, patients and customers.
- People who didn't know the person who died.

[23] http://uk-sobs.org.uk/suicide-bereavement/how-suicide-can-affect-you/how-suicide-affects-others/

Appendix 3: consequences of a failed suicide attempt

It is very important that family and friends know what to do and what to be alert for after someone they care about has had a suicide attempt.

Research shows that in the days, weeks and months immediately following an attempt is the time when the person needs a lot of support and that is a time that he is most at risk of suicide.

Only 10% of the people who attempt suicide will go on to complete and die by suicide. But 80% of those who die by suicide have made a previous attempt. So while chances are that this person won't attempt again, he or she is also at an increased risk for dying by suicide.

The first six months after a hospitalization are especially critical to the suicide attempt survivor, and the person remains at an elevated risk for the entire first year. Also know that research shows that 90% of those who die by suicide had a diagnosable mental illness at the time of death. (Depression, bipolar disorder, anxiety, substance abuse, eating disorders, yet most people with a mental illness do not die by suicide).[24]

The consequences of a failed suicide attempt can be catastrophic for the individual. Some of these suicide methods and the effects of failure are listed below. However, all methods present the potential for physical and/or brain damage if the suicide method is not successful.[25]

[24] http://www.griefspeaks.com/id121.html
[25] http://www.suicide-thereishope.com/pitfalls.htm

Contact information

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