7.4.4 Suicide prevention

Why is this issue important?

Deaths by suicide are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides.\(^1\)

In England, one person dies every two hours as a result of suicide.\(^1\) The highest risk is among men in their 40s,\(^1\) so many years of life may be lost. When someone takes their own life, the effect on their family and friends is devastating. Every suicide affects a number of people directly and often many others indirectly.

A national strategy for preventing suicide was published on 10 September (World Suicide Prevention Day) 2012. This strategy identifies the following high risk groups:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers.

Key outcomes

- **Suicide rate (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Brighton & Hove has had a higher rate of deaths from suicide than England for the past century.\(^2\)

Information about deaths by suicide among our residents is available from the Office for National Statistics\(^3\); HM Coroner for Brighton & Hove also keeps records of the deaths which take place within her jurisdiction.


The most recent three-year aggregated rates available from ONS are based on 2009-11 and are published provisionally because of changes to the codes used to record these deaths and because of changes to population estimates following the 2011 census.

The provisional standardised rate for deaths from suicide and injury undetermined for Brighton & Hove residents is 11.1 per 100,000. This is 41% higher than the rate for England of 7.9 per 100,000. Brighton & Hove ranks 10\(^{th}\) in the country, a relative increase from 2008-10, when the City ranked 20\(^{th}\) amongst local authorities.

Annual rates are based on small numbers and are therefore less reliable than trends based on three-year aggregates. In 2011, 38 deaths for our residents were identified by ONS; the rate has risen in 2011.

**Figure 1: Suicide and injury undetermined: annual trend, directly standardised age rate, all ages 2000-2011**


The trend shown in Table 1 should be interpreted with caution, as the 2011 rate uses revised population figures based on the 2011 census, and previous years population estimates have not yet been revised. However, given the increase in the population, an underestimate of the population in previous years would be expected to show a disproportionately high rate.

The local audit of Coroner’s records shows that for deaths where the verdict was suicide, the most common method used was hanging:
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Table 1: Method for Brighton & Hove deaths with suicide verdict 2003-2010

<table>
<thead>
<tr>
<th>Method</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>94</td>
<td>46%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>54</td>
<td>27%</td>
</tr>
<tr>
<td>Jumping</td>
<td>17</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>38</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: Audit of records, HM Coroner Brighton & Hove

Table 1 above shows the proportions for deaths with a suicide verdict only; if the wider group of verdicts including open and narrative are included, the proportion of deaths by self-poisoning rises from 27% to 29%.

Table 2, below, shows the most common place for deaths to take place, by far, is at home.

Table 2: Place of death for Brighton & Hove deaths with suicide verdict 2007-2010

<table>
<thead>
<tr>
<th>Place</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>63</td>
<td>72%</td>
</tr>
<tr>
<td>Beach / cliff / water</td>
<td>9</td>
<td>10%</td>
</tr>
<tr>
<td>Railway lines, station or crossing</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Audit of records, HM Coroner Brighton & Hove

The combination of these factors – place and method - makes preventive action such as barriers less likely to be effective. Prevention will need to address the underlying causes of the impulse or wish to die.

Local inequalities

Audit of the Coroner’s records provides a more detailed understanding of high risk groups among the local population and the circumstances surrounding their deaths. 203 deaths with a suicide verdict and 262 deaths with a narrative, suicide or open verdict between the years from 2003 – 2010 were included in the analysis.

Age: The local pattern for age groups most at risk mirrors the national pattern: the highest risk is in those aged 35 – 49, with a significant secondary risk group in the elderly.

Gender: The gap between male and female rates was narrower in Brighton & Hove in the mid-decade but appears to be widening again, with female rates much lower than male rates in 2009 and 2010. Nationally, men are three times more likely to die from suicide than women.1

Figure 2: Suicide verdicts 2003 – 2010 by gender

Lesbian, gay, bisexual and transgender (LGBT): The Count Me in Too survey of LGBT people in the City4 found that 23% have had suicidal thoughts with 7% attempting suicide in the past five years. Risks of suicide and suicidal vulnerabilities vary: those who identified as bisexual, queer or ‘other’ in terms of sexuality, trans people, young people, those who feel isolated, those on a low income, abuse survivors, the homeless and those who are disabled and/or long-term health impaired are more likely to report having experienced suicidal thoughts or to have attempted suicide.

The audit of local Coroner’s records appears to show that the proportion of deaths by suicide among the LGBT community at 11% is lower than the proportion of people identifying as LGBT in the population at 17%. However, information about sexual orientation is not systematically recorded as part of the Coroner’s records so this may be an under-estimate.

## 7.4.4 Suicide prevention

**Ethnicity:** The local audit suggests that there are more deaths among Black Africans and fewer among Asian or Mixed groups than would be predicted given our proportion of these groups in the city. However, numbers are very small, so this may not be reliable.

**Deprivation:** The local audit of deaths with suicide, or relevant open or narrative verdicts shows a higher proportion in the most deprived quintile (30%) than the least deprived quintile (15%), based on home postcode. Of those who died, 38% were unemployed compared to 8% in the overall population of the city; 19% were retired.

**Other risks:**
The local audit found a high proportion of people with a mental or physical health problem: 23% had a physical health problem; 11% suffered chronic pain. A national report found that at least 10% of the suicides in the UK are by chronically or terminally ill people.5

From 2007-10, 70% of people included in the local audit had a mental health diagnosis and 57% had a history of previous self-harm or suicide attempts. Depression was the most common diagnosis, recorded in over 50% of deaths.

Stressful life events are identified nationally as a risk factor and the local audit confirms this: 18% had financial problems, 57% had difficulties in their primary relationships, 22% had suffered significant bereavements; 6% had lost a close relative or friend to suicide in their lifetime.

The local audit showed that around half of people taking their own lives had an alcohol or a drug misuse problem. A similar proportion had suffered abuse or had a history of being violent themselves. Over one in ten had a history of offending.

People living alone are at increased risk of suicide: 53% of people who died were living alone; 36% of our residents live in one-person households, according to the 2011 census.

Carers appear to be under-represented: only 1% of people who died by suicide were carers.

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**Where we are doing well**

We are fortunate to have a local Coroner willing to allow access to the records of local inquests. Much of the detailed local information needed to inform prevention work is dependent on this access.

The city has a local strategy to prevent suicides; a multi-agency group steers its implementation. The history of high suicide rates has led to local investment in prevention initiatives including:

- Meetings between clinicians involved in providing care for an individual, following a death by suicide, to identify any learning that could be shared.
- A pack for all GP practices including a local risk assessment questionnaire.
- Suicide prevention training for frontline staff working with high risk groups.
- Work towards a Suicide Safer City, aiming to encourage people to talk about suicidal feelings and to reduce stigma.
- Support and resilience building work with higher risk groups such as young people identifying as LGB or Trans or people living in East Brighton.
- Online round-the-clock support for people with low level mental health problems or suicidal feelings.
- An audit of people presenting with self-harm at A&E to identify gaps or risks in the service; improved access to urgent care;
- Improved safety at the Mill View hospital, in line with independent recommendations, including changes to the reception area;
- A multi-agency working group to address high rates of self-harm among young people;
- Celebrations to mark World Suicide Prevention Day each year in the city.

**Predicted future need**

Future trends are hard to predict, however times of economic hardship are linked to higher rates of suicide and national incidence has risen since 2008. The local rate also rose in 2011, the last year for which ONS information is currently available.
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What we don’t know

Coroner’s verdicts vary between areas and we do not fully understand the impact of this on local data, especially the increased use of narrative verdicts. New advice for Coroners on coding for deaths was published in 2011: this covered coding for deaths by poisoning, drug dependence and use of narrative verdicts. Furthermore, local rates will need to be adjusted for the 2011 census. The impact of all these factors on local trends is unclear at present.

Views and commentary from local communities, especially from groups at higher risk, would help to inform strategy priorities.

Key evidence and policy

The national strategy, Preventing Suicide in England, identifies the following groups for whom a tailored approach to mental health is necessary if their suicide risk is to be reduced:

- 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.

The Scottish government social research department has published useful advice on risk and protective factors. 6

Recommended future local priorities

The suicide prevention action plan for Brighton & Hove is agreed by the multi-agency Suicide Prevention Strategy Group each year. For 2013-14, there are four key priorities:

1. Analysis of the Coroner’s records to identify local risks and patterns, with trends over time;
2. Shared learning from review of deaths by suicide, to identify any action that might prevent such deaths in future;
3. Risk reduction among people who self-harm;
4. Support for those bereaved by suicide or concerned about others at risk.

The action plan also records local progress against the six key areas for action priorities identified in the national strategy:

1. Reduce risk of suicide in key high-risk groups;
2. Tailor approaches to improve mental health in specific groups;
3. Reduce access to the means of suicide;
4. Provide better information and support to those bereaved or affected by a suicide;
5. Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour;
6. Support research, data collection and monitoring.

Key links to other sections

- Substance misuse
- Mental health
- Dual diagnosis
- Social connectedness
- Emotional health and wellbeing
- Alcohol

Last updated

May 2013

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