Tower Hamlets Suicide Prevention Strategy 2017-2020

Background Document

Tower Hamlets
Health and Wellbeing Board

Contents

1. Introduction

1.1. 6,188 people died due to suicide in the United Kingdom in 2015. Nationally, it is the leading cause of death in adults aged 20-34[1,2]. It is one of the 20 leading causes of death worldwide[3].

1.2. Every suicide has a wide-ranging impact on the families, friends, colleagues, and healthcare workers associated with the victim. An estimated 60 people are affected by each suicide[4]. It is both a personal tragedy and a loss for society. The estimated financial cost of an individual suicide in a working age person is £1.67m[5].

1.3. Suicide is not inevitable. Public health measures to reduce access to means and improve care for those who are at risk of suicide have contributed to a reduction in the national suicide rate since the 1980s. However, there has been an upturn in deaths by suicide since 2008; there remains a need for preventative work.

2. Policy context

2.1. In 2013 public health was transferred from the NHS to local government, placing suicide prevention work in the remit of the local authority.

2.2. In 2012 the National Suicide Prevention Plan (NSPS) Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives identified six key areas of action[6]:

1. Reduce the risk of suicide in key high-risk groups

- Men
- People with a history of self-harm
- People with a history of alcohol and drug misuse
- People under the care of mental health services, including inpatients
- People in contact with the criminal justice system
- Specific occupational 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 suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

2.3. In 2014 Preventing Suicide in England 'One Year On' suggested the following local actions[7]:

- Develop a suicide prevention action plan
- Directors of Public Health to monitor local data and trends
- Engage with local media regarding suicide reporting
- Work with transport and the health and wellbeing board to map local 'hotspots'
- Work on local priorities to improve mental health

2.4. In 2015 Preventing Suicide in England 'Two Years On' was published. In line with the All-Party Parliamentary Group on Suicide and Self-Harm Prevention, it identified three elements key to local implementation of the national strategy[8]:

- Carrying out a suicide audit through sources such as the coroner's office and health records
- Developing a suicide prevention action plan detailing specific actions to reduce suicide and suicide risk in the local community
- Establishing a multi-agency suicide prevention group involving key statutory agencies and voluntary organisations

2.5. In 2016, the Five Year Forward View for Mental Health made it a requirement of all local authorities to have a suicide prevention strategy in place, with the aim of reducing the national suicide rate by 10% from 2015/16 to 2020/21[9].

3. Aims

3.1. Local needs are identified through the multi-agency suicide prevention steering group, and an audit of suicide in Tower Hamlets. National guidance, as detailed in Public Health England's (PHE) Local Suicide Prevention: a practice guide[10], has been taken into account.

3.2. The strategy sets out how reducing suicide risk in Tower Hamlets will be addressed. The action plan outlines the specific work that will achieve this.

3.3. The strategy takes a broad approach to improving mental health and wellbeing in order to reduce suicide risk. It focuses on five priority areas of work:

- Early intervention and prevention
- Improving help for those in crisis
- Identifying the needs of vulnerable people
- Addressing training needs
- Communications and awareness

3.4. Although there is overlap, these priorities differ from the key areas of action identified in the NSPS (see section 2.2 above). They are reflective of the collective priorities of the agencies working on suicide prevention in Tower Hamlets. Individual organisations will also be carrying out work which may not be directly reflected in the priorities.

4. Discussion and consultation

4.1. Discussion

Prior to public consultation, the Suicide Prevention Strategy was discussed at directorate management teams across the council: Health, Adults, and Community; Children's Services; and Place.

4.2. Zero suicide

The zero suicide approach originated in the USA, where a mental health service developed a system of 'perfect depression care', which saw the suicide rate amongst its patients drop by 75% in ten years, including a year without any suicide[11]. The approach takes the premise that no suicide is unavoidable.

Adopting such an approach requires a fundamental shift in how suicide is viewed, from being a part of mental health care in general, to becoming a 'never event'. Areas which have implemented the zero suicide approach have created dedicated suicide prevention teams, increased access to same-day mental health services, lowered the threshold for what is considered to be suicide risk, and developed live reporting of suicide.

It has been suggested that zero suicide is an unrealistic goal which ultimately sets clinicians up to fail. However, health services in which this approach has been applied to good effect have reported that having such a bold goal helped to focus their efforts.

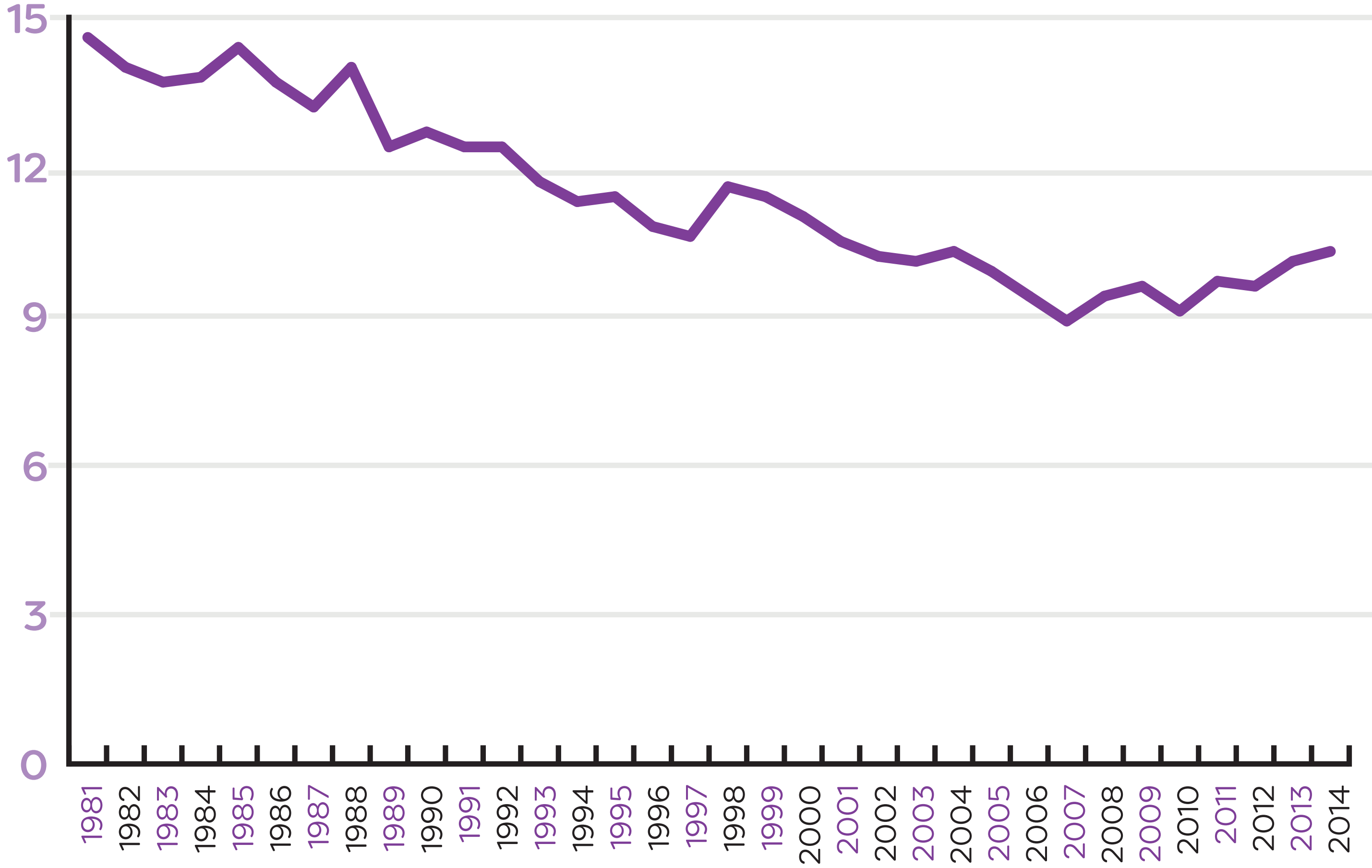
Concerns have also been raised about the language used, with 'zero suicide' echoing policies such as 'zero tolerance' on drugs and violence. It is clear that the way in which any aspiration is expressed must not contribute to the stigma already surrounding suicide.

5. National background

5.1. 6,188 people died by suicide in the United Kingdom in 2015[12].

5.2. The suicide rate in England is currently 10.1/100,000 population[13]. Although the rate had been declining steadily since 1980, there has been an increase since 2008.

Figure 1: Suicide rate in England 1981-2014

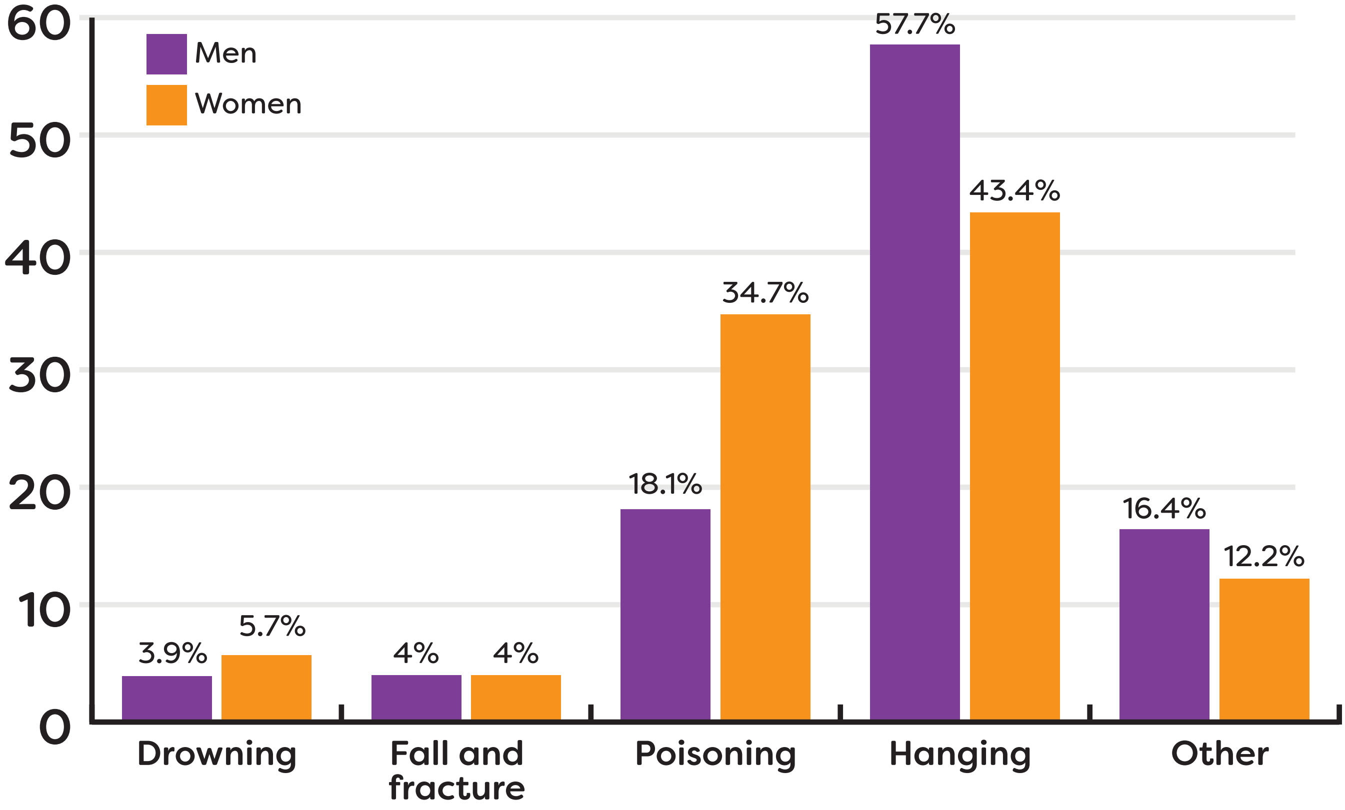


5.3. Suicide is the leading cause of death in young people aged 20-34[14]. The rate amongst males is consistently three times that of females[15].

5.4. The most common method of suicide in England and Wales is hanging or suffocation, followed by overdose or poisoning[16].

Figure 2: Methods of suicide by percentage in men and women in England and Wales

Office for National Statistics 2015



5.5. Recognised risk factors for suicide include[17, 18, 19]:

- Male, young to middle-aged adults
- History of self-harm
- Inpatients under the care of mental health services
- Chronic mental or physical illness
- Contact with the criminal justice system
- Occupational or geographical access to means

5.6. Acute events which increase the risk of suicide include[20, 21]:

- Bereavement
  Bereavement by suicide is known to increase the risk of suicide attempts in young adults compared to bereavement through sudden death by natural causes[22].
- Loss of employment
- Relationship breakdown
- Imprisonment
- Debt

6. Children and Young People

6.1. Suicide is a leading cause of death in children and young people (CYP), and is traumatic for all those affected. Although many of the risk factors already explored apply to this age group, there are also specific factors to be aware of. The Suicide by Children and Young People in England report from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) offers a comprehensive review of these risks[23].

6.2. The report identifies ten key themes common to many of the deaths by suicide in the under-20s:

Figure 3: NCISH key themes of suicide in children and young people

- Mental illness, substance misuse, and domestic violence in family members
- Academic and exam pressures
- Physical, emotional, or sexual abuse, or neglect
- Social isolation or withdrawal
- Bereavement in a family member or friend
- Physical health conditions that are longstanding or have a social impact
- Bullying, either in person or online
- Excessive alcohol use or illicit drug use
- Suicide-related internet use
- Mental ill health, suicidal ideation, self-harm

6.3. Concerns have been raised locally about the possible negative impacts of social media on CYP. Almost a quarter (23%) of deaths in under 20s were preceded by 'suicide-related internet use', including searching for methods, and discussing suicidal ideation online[24]. Social media is a rapidly growing platform and its impact on young people's mental health is not fully understood[25].

6.4. Of note, nearly half (43%) of under 20s who died by suicide were not known to any statutory service (including mental health services, social care, or the criminal justice system).

6.5. More than half (54%) of under 20s who died by suicide had a history of self-harm. The rate of self-harm in CYP is increasing. In England hospital admissions as a result of self-harm in 10-24 year olds increased by 24% between 2010 and 2015[26]. Self-harm and suicide share a profile of risk factors, including chronic illness, social isolation, emotional trauma, and alcohol and drug misuse.

6.6. A key message from the report is that many (43%) CYP who die from suicide have not recently expressed suicidal ideation. Key to reducing risk is recognising the cumulative effect of multiple risk factors over time, and being aware that any single event may act as the 'final straw'. The NCISH report offers this model:

Figure 4: NCISH model of cumulative risk

Early life experience can make young people vulnerable e.g. family mental illness → **As they get older other issues may arise e.g. alcohol use** → **One event may act as the 'final straw' e.g. exam stress**

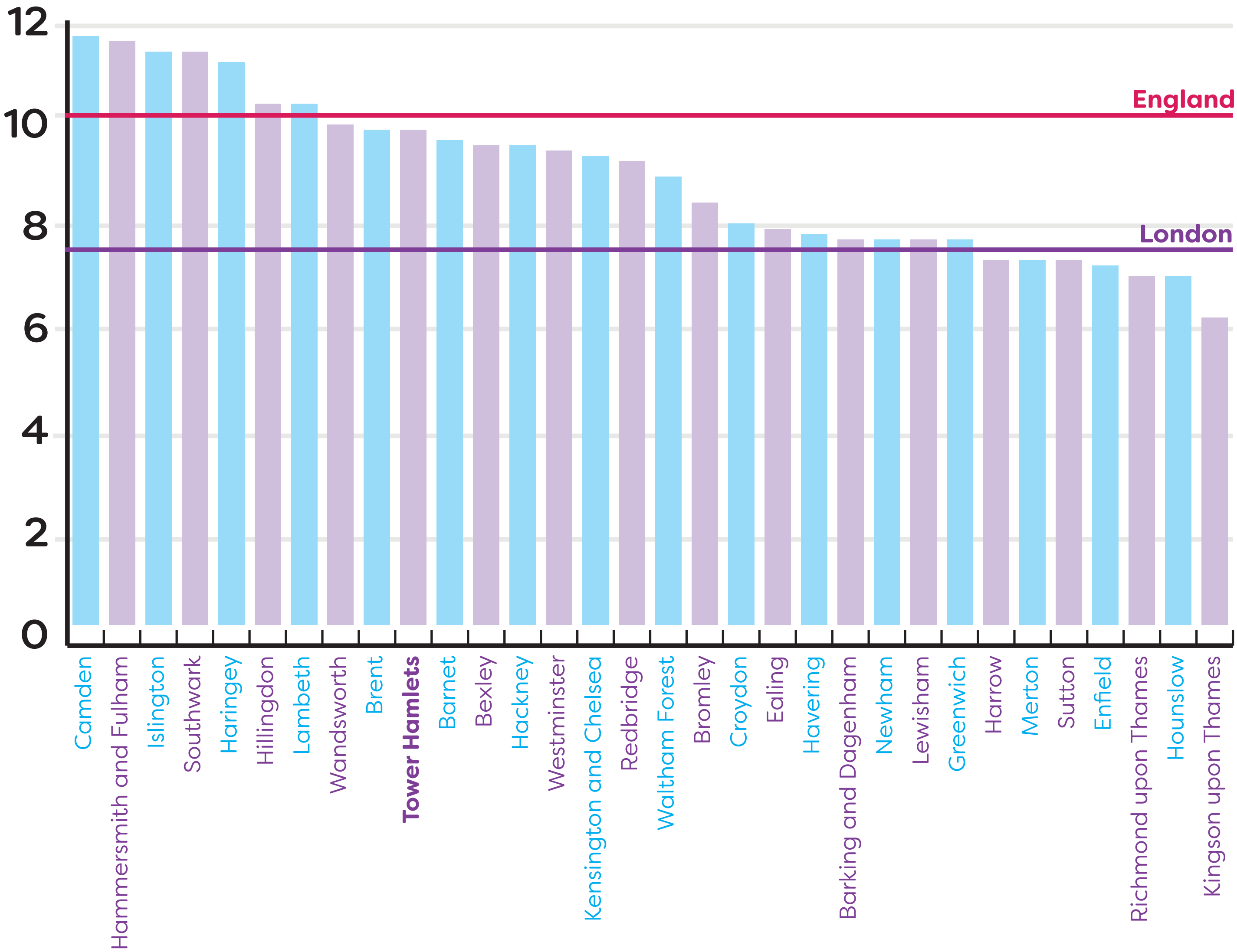
6.7. It is also important to note that many of the common factors in the deaths examined in the NCISH report are also common to the CYP population at large; an illness such as asthma cannot be viewed as a predictive factor for suicide. Some risk factors may be under-reported if of a sensitive nature (e.g. abuse), or over-reported by friends or family seeking a cause for the death (e.g. exam stress)[27].

7. Local data

7.1. The suicide rate in Tower Hamlets is currently 9.5/100,000 population; the London rate is 8.6 and the England rate is 10.1[28]. In the years 2013-2015, Tower Hamlets had the tenth highest rate amongst the London boroughs.

Figure 5: Suicide rates 2013-2015

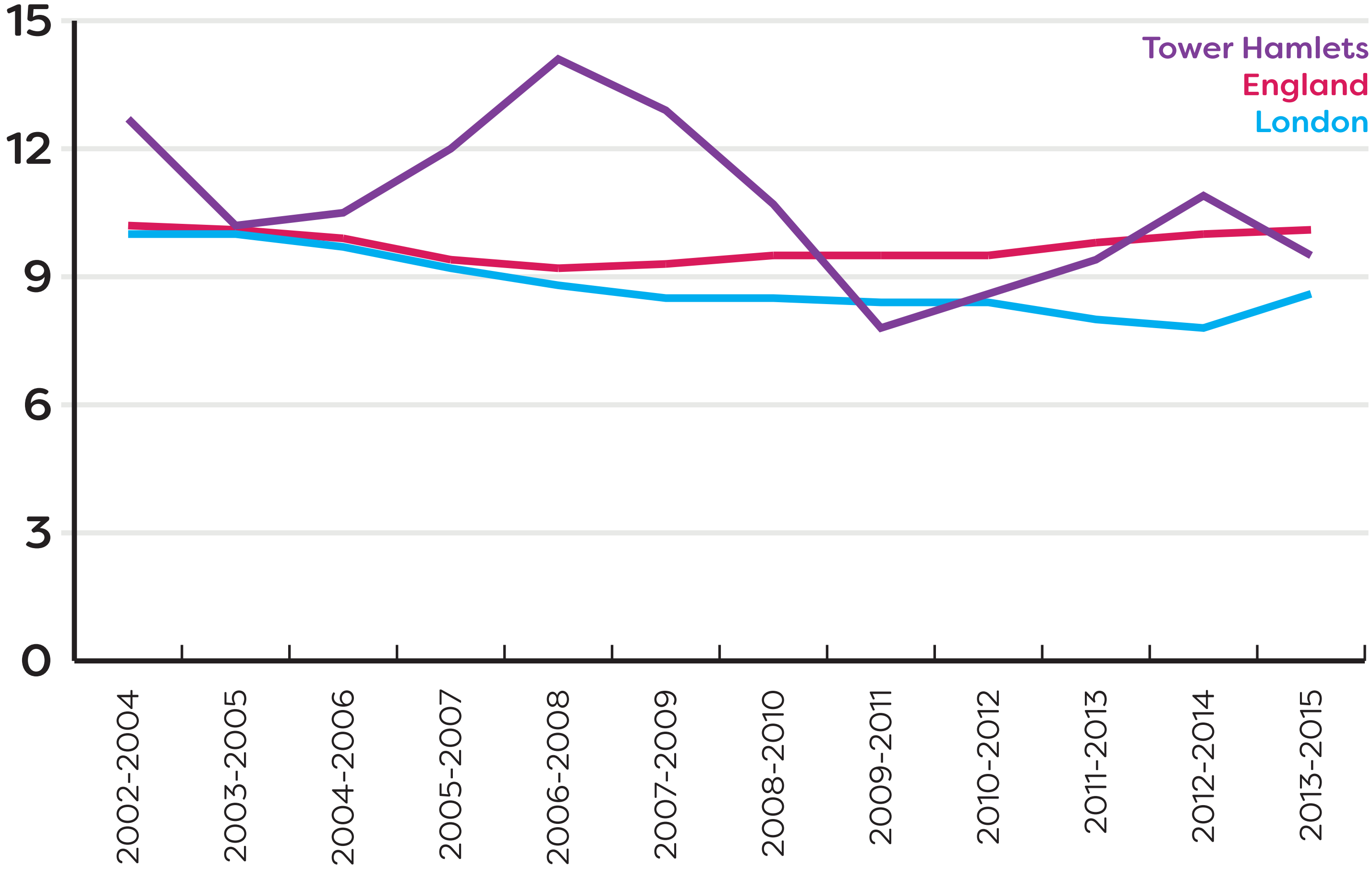
Three-year aggregate age-standardised suicide rates in London boroughs, London, and England. Office for National Statistics 2013-2015



7.2. The suicide rate in London has been decreasing gradually over the past ten years. The local rate has fluctuated. The small numbers involved preclude a trend being identified.

Figure 6: Suicide rates per 100,000

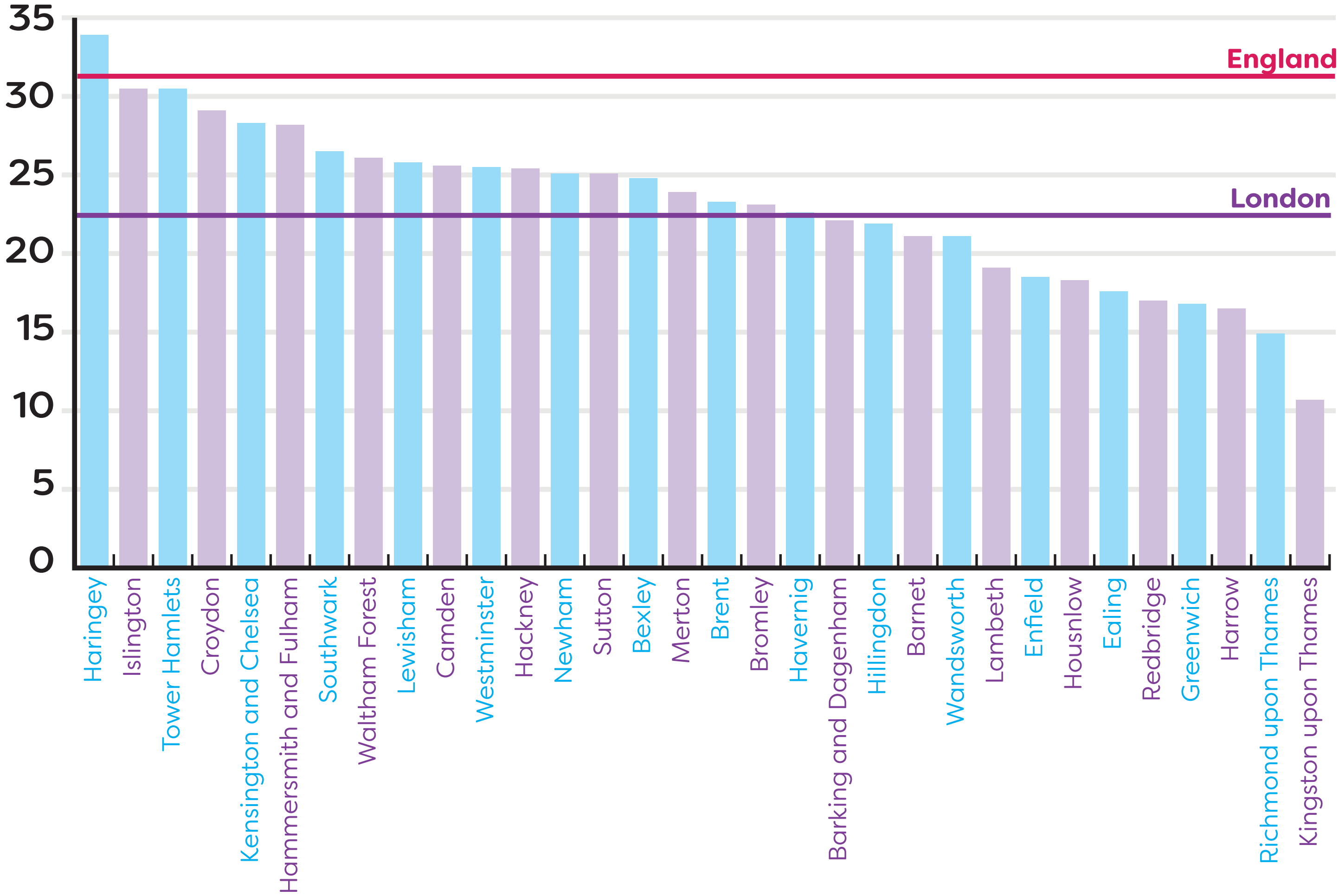
Three-year aggregate suicide rates per 100,000 persons in Tower Hamlets, London and England. Office for National Statistics 2002-2004, 2013-2015



7.3. The rate of years of life lost per 10,000 population is 30.5. It is reflective of the relatively young population in Tower Hamlets.

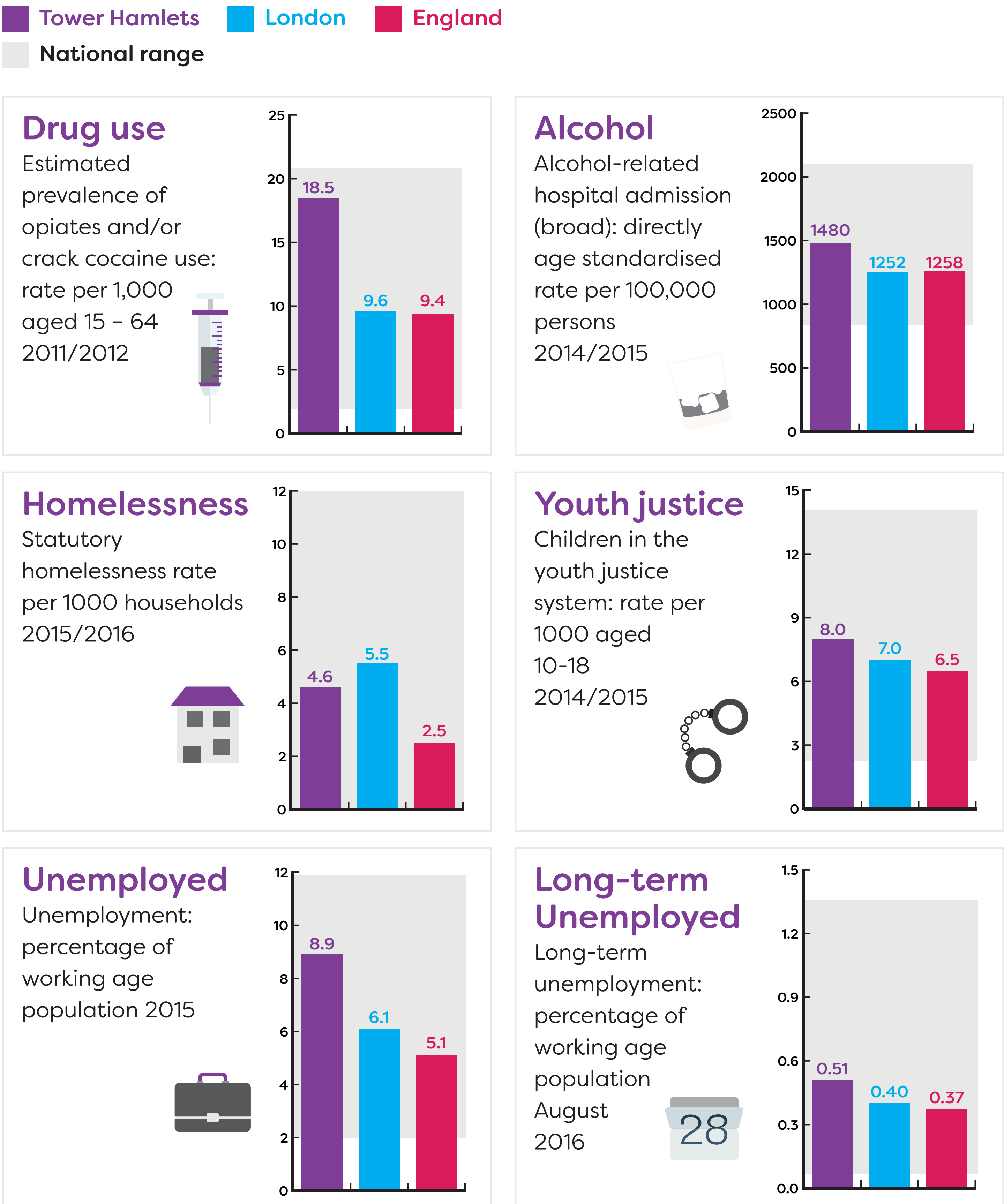
Figure 7: Years of life lost due to suicide (15-74) per 10,000 2012-2014

London boroughs, London, and England. Office for National Statistics, 2012-2014



7.4. PHE identifies public health outcomes associated with an increased suicide risk. Tower Hamlets has a rating significantly worse than the national average for several of these. Of note:

Figure 8: Public health outcomes associated with an increased suicide risk



7.5. Key concerns raised by the Suicide Prevention Steering Group include:

- A number of serious incident reviews have been conducted but learning has not been collated and shared between agencies.
- There have been multiple suicides and deaths of unknown intent in young adults who have been housed in temporary accommodation.
- There is at least a perceived lack of information on what crisis services are available.
- There is a lack of clarity over referral pathways, within and between statutory and voluntary sector agencies.
- Non-clinical frontline staff, such as those in the housing department, benefits office, and job centre, do not feel equipped to deal with mental health crises.
- There have been instances where staff, for example in hospitals and schools, have hesitated to report concerns either because they are unsure of who to report to, or due to a fear of breaching confidentiality.
- There is no consistent access to detailed information from the coroner.
- Working towards a 'zero-suicide' target should not be pursued by increasing the number of patients who are under mental health sections or hospitalised.

7.6. Tower Hamlets suicide audit 2006-2016
It is a recommendation of the NSPS and its 2015 follow-on report that a local suicide audit is conducted. Its aim is to provide data which will inform a local suicide prevention strategy. Given the small numbers involved locally, this data should be used alongside national and international evidence to inform targeted local actions.

Methodology
In line with best practice, four sources of data were considered[29]:

- The local coroner's office: Inner North London
- Local accident and emergency (A&E) departments
- The Primary Care Mortality Database (PCMD)
- Data compiled and published nationally by the Office for National Statistics (ONS)

The Inner North London coroner's office was contacted with a view to forming a data sharing partnership. This has so far been declined due to confidentiality concerns. Local A&Es do not routinely audit suicide and self-harm.

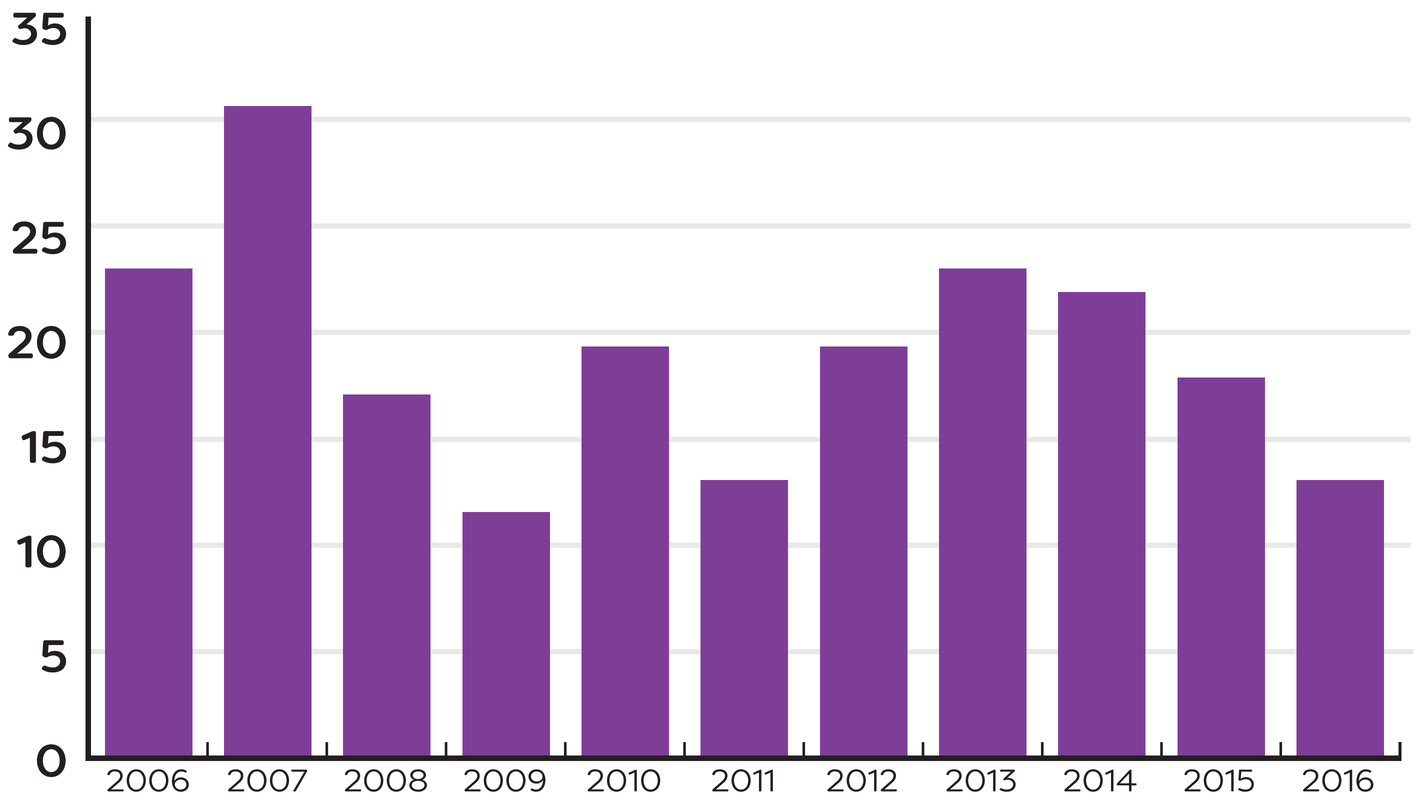
Data from the PCMD has been used to examine deaths recorded as suicide. These have been examined in terms of gender, age, method, location, residency, and country of birth. Data would ideally be broken down by the nine protected characteristics[30], and the nationally recognised risk factors for suicide, but this is not routinely recorded on death certificates. The data fields collected in the PCMD are listed in full in Appendix 1. National data from the ONS has been used to make comparisons with other areas.

Extraction of data from the PCMD:

- There were 11569 deaths of Tower Hamlets residents between January 2006 and September 2016.
- 218 deaths were assigned an ICD-10 code for suicide. This is the population used in the audit.
- 85 deaths assigned an ICD-10 code for suicide were open verdicts; 133 were not.

Demographics

Figure 9: Yearly suicide counts in Tower Hamlets



Gender

Over the ten year period, 81.2% of suicides have been in men and 18.8% in women, a ratio of 4:1.

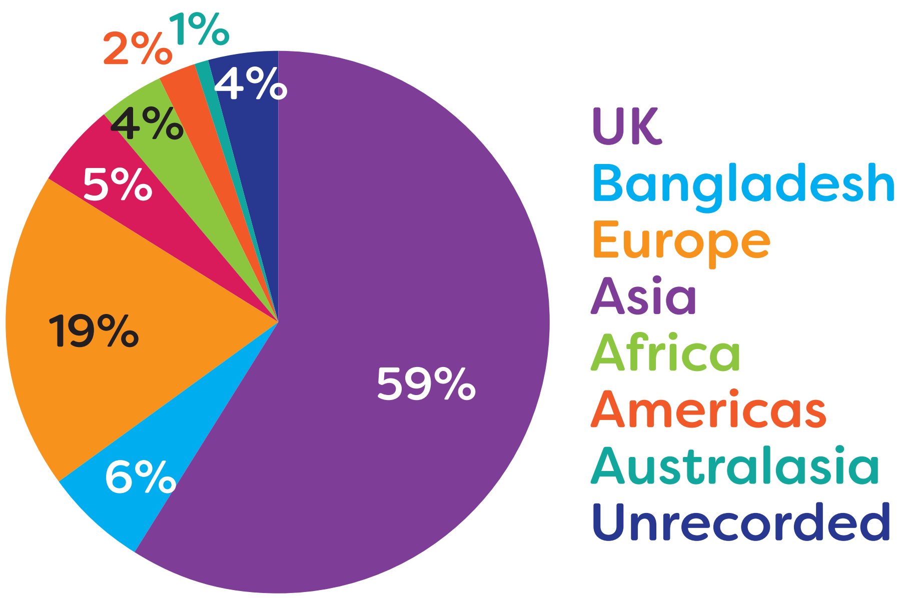
Age

Over half of all suicides in both males and females are in the age range 20-39. A quarter of all suicides are committed by males aged 30-39. There have been no suicides in females over the age of 60.

Country of birth

Death certificates do not record ethnicity. The closest approximation of this is country of birth. 59% of all suicides were by people born in the UK. 6% were by people born in Bangladesh.

Figure 10: Percentage of suicides 2006-2016 by country of birth



Deprivation

It is recognised nationally that there is a positive correlation between suicide rate and deprivation. However, on a ward level in Tower Hamlets this is not apparent:

- Bow East has had the highest number of suicides in the past decade, both by count and rate per 1000 population[i], but is the 12th most deprived of 20 wards in the borough.
- Poplar and Limehouse have the joint lowest suicide counts, and equal rates per 1000 population, but are the 9th and 16th most deprived wards respectively.
- 4% of deaths in Blackwall and Cubitt Town are due to suicide, the highest proportion in the borough. It is the third least deprived ward.

i Based on the current population count

Occupation

PHE's advice on local suicide prevention identifies high-risk occupations as:

- Doctors
- Nurses
- Farmers and agricultural workers
- Veterinary workers
- Roles with poor working conditions and low job security

Of the 135 suicides with a recorded occupation, there were two nurses and one doctor. The association between certain occupational groups and suicide is not represented in Tower Hamlets.

Of note, although not identified nationally as a risk group, 14 students have died by suicide over the past decade, accounting for 6.4% of suicides.

Registration with a GP

25 people who died by suicide were not registered with a GP surgery: 11.5%.

Method

Injury (comprising 'injury', 'multiple injury', and 'wound') and hanging are the most common methods of suicide in Tower Hamlets, accounting for 36% and 31% of suicides respectively. Nationally, hanging is the most common method.

Suicides caused by injury are more likely to have an open verdict, even if they are also assigned an ICD-10 code for suicide, than suicides by hanging. This is reflective of the difficulty in determining intentions after a person's death.

Poisoning, including by opiate drugs, makes up the greatest proportion of suicides in women; injury makes up the greatest proportion of suicides in men.

Figure 11: Percentage of suicides by method in females, 2006-2016

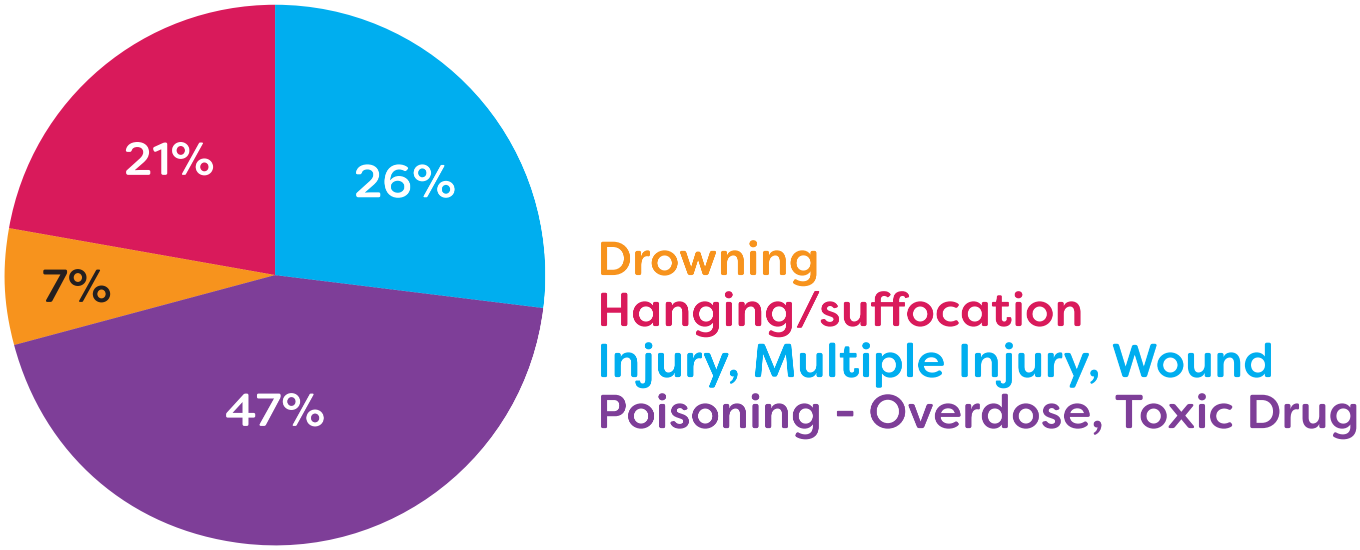
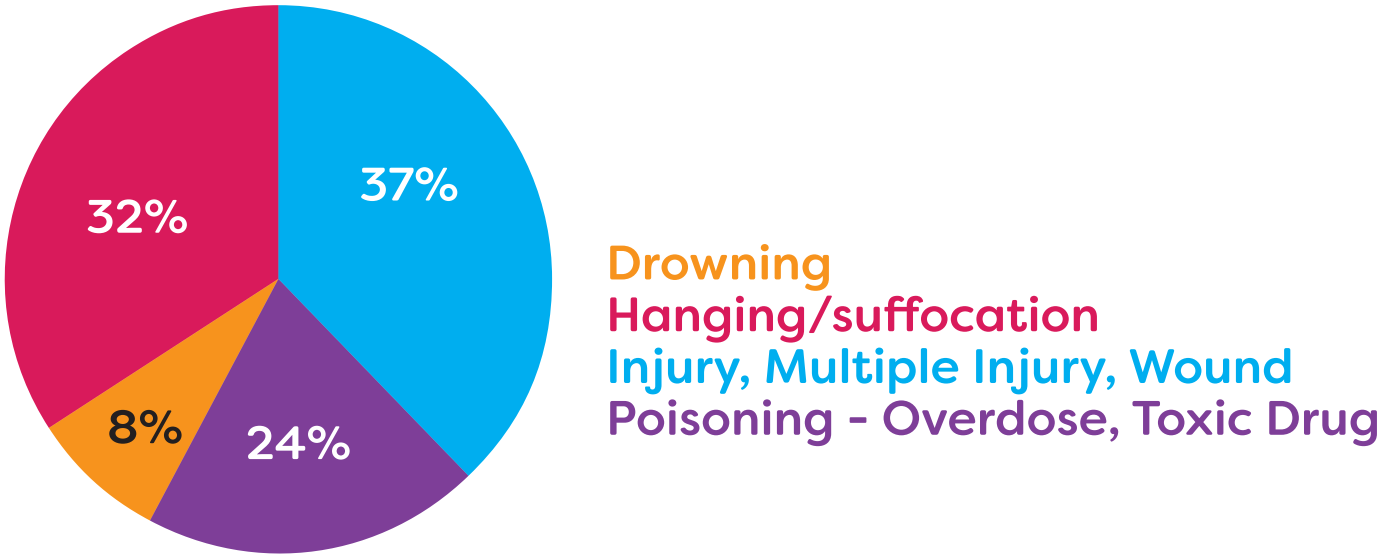


Figure 12: Percentage of suicides by method in males, 2006-2016



Location of death

88 deaths occurred in the home of the victim.

43 deaths occurred in hospital. In the vast majority of these cases, the victim had undertaken the act of suicide elsewhere, and later died in hospital.

Three cases were identified as hangings in healthcare settings.

There were 13 deaths at train or underground stations, of which seven were within the borough.

Hotspots

Two sites are identified where more than one person has died by suicide in the past decade:

- Bethnal Green Underground Station
- Mile End Underground Station

British Transport Police data shows three suspected suicides and one injurious attempt at Mile End Underground Station between April 2015 and February 2017[31]. This does not correlate with PCMD data; suspected suicides will not necessarily be given a suicide verdict by the coroner.

Limitations

The findings are limited by:

- Restricted access to data sources e.g. coroner's records
- The way in which data is recorded
- The small size of the data set

The data presented here is from the PCMD, and is therefore limited by what variables are included in the database and how fully each of these has been populated.

Data is also limited by what is recorded on a death certificate. Neither the death certificate nor the PCMD record information on seven of the nine protected characteristics:

- Disability
- Gender reassignment
- Marriage/civil partnership
- Maternity/pregnancy
- Race
- Religion
- Sexual orientation

PHE guidance on suicide prevention planning recommends reducing the risk of suicide in key high-risk groups. Information relevant to these groups is not included in the PCMD:

- Recorded history of self-harm
- Recorded history of misuse of drugs and alcohol
- Known contact with mental health services
- Contact with the criminal justice system
- Occupation is often incompletely recorded

Data is not routinely collected on attempted suicide; no distinction is made in hospital data between self-harm and suicide attempt incidents.

Local data from the PCMD offers an insight into suicide in Tower Hamlets, but should be considered in conjunction with national data due to the small numbers involved.

The demographics of the Tower Hamlets population should be considered when looking at high suicide risk groups. There have been several suicides in the student population which is not identified as a high risk group in national guidance. Students make up 15.4% of the 16-74 year old population in Tower Hamlets[32]. The specific occupational groups identified in national guidance such as agricultural workers are not relevant to the local population.

8. Current work

8.1. Work on suicide prevention is already ongoing in Tower Hamlets. Key services and work, beyond the statutory mental health services, are summarised below.

8.2. Work from London Borough of Tower Hamlets:

- Mental Health Strategy 2014-2019
- Provision of Mental Health First Aid (MHFA) training to around 200 local staff and further training for 12 local staff to become MHFA trainers
- Community perspectives on loneliness in the over-50s project
- Provision of mental health safeguarding workshops for frontline staff in adult social care
- The Recovery and Wellbeing Service, operating from January 2017
- The council is signed up to the Local Authority Mental Health Challenge and to the Time to Change Employers' Pledge

8.3. Specialist services provided by East London NHS Foundation Trust:

- Rapid Assessment, Interface, and Discharge (RAID)
- A model for psychiatric care which provides rapid assessments to those in mental health crises both in A&E and as inpatients.
- Tower Hamlets Early Detection Service (THEDS)
- A service for young people aged 16-25 who are concerned about their own mental health. Patients can be referred by non-health professionals and can self-refer. The service provides mental health assessments and offers sessions with an emphasis on building emotional resilience.
- Criminal Justice Mental Health Liaison Service (CJMHLS)
- A service for people who are in contact with the criminal justice system. The service provides healthcare professionals to assess those in a custodial setting (police stations, courts, and prisons) for suicidal ideation, mental health conditions, and learning disabilities.

8.4. Voluntary sector work

- **City and East London Bereavement Service (CELBS)**
  A voluntary sector organisation which has been commissioned to provide bereavement counselling, including for those as a result of suicide. This service is accessible to any patient living in Tower Hamlets, or whose relative or friend died within a Barts Health NHS Trust hospital. Patients can be referred from primary care, IAPT, or can self-refer.

- **Samaritans**
  Provides a free 'listening service' over the phone, by email, or face to face in central London. They have distributed literature on suicide prevention and emotional resilience to all secondary schools in the borough.
- **Look Ahead**
  Provides crisis and recovery houses as an alternative to hospital admission.
- **Compass**
  Provides Improving Access to Psychological Therapies (IAPT) service, and provides counselling focusing on wellbeing and emotional resilience.
- **Mind in Tower Hamlets and Newham**
  Provides counselling, training, and a diverse range of activities to improve mental health and wellbeing.
- **Inspire Mental Health Consortium**
  Delivers mental health and wellbeing services including housing, support, and training.
- **Campaign Against Living Miserably**
  Provides a free listening service by phone or online, specialising in assisting men.
- **Papyrus UK**
  Provides HOPEline, a free telephone service aimed at young people (16-30).

8.5. Transport services

- Railways and London Underground staff are trained in suicide prevention via Transport for London, British Transport Police, and Network Rail.
- Network Rail and the British Transport Police collect information regarding deaths on railways and TfL sites. Three incidents or more at one site within a twelve month period are automatically escalated to the local authority.

8.6. Education

- **Queen Mary's University of London**
  Provides counselling sessions for students and is conducting research into suicidal behaviour

8.7. Much of this work can be mapped to the six key areas of action identified by PHE and the NSPS. However, the multi-agency steering group has decided Tower Hamlets should have slightly different priorities over the next three years.

9. Next steps

9.1. Taking into consideration the concerns raised by stakeholders, local mortality data, and national guidance, the steering group decided on five priorities for collective work.

9.2. The priorities, why they were chosen, and the long and short term aims are outlined in the Tower Hamlets Suicide Prevention Strategy.

9.3. The specific actions to take over the next year are details in the Tower Hamlets Suicide Prevention Action Plan.

10. Appendix 1: PCMD variables

1. Anonymised ID
2. First all-numeric NHS number
3. Date of birth
4. Date of death
5. Place of death text
6. Usual address of deceased in text
7. Postcode of usual address
8. Cause of death text lines 1 to 8
9. Strategic Health Authority code of residence
10. Primary Care Trust or Local Health Board code of residence
11. Date of registration
12. Sex
13. Underlying cause of death ICD code
14. Cause of death ICD Codes 1 to 8
15. Certifying Doctor
16. GP Code that the deceased was registered with
17. GP Practice Code that the deceased was registered with
18. CCG code for the GP practice that the deceased was registered with
19. Place of death code
20. Postcode of place of death
21. Clinical Commissioning Group code for place of death of deceased
22. Upper tier Local Authority code for place of death
23. Primary Care Organisation code for place of death

24. NHS Establishment indicator
25. Establishment type where death occurred
26. Postcode imputation indicator
27. Calculated age of deceased
28. Calculated age unit
29. Occupation of deceased in text
30. Occupation of husband or father of deceased juvenile (text)
31. Occupation of mother of deceased juvenile (text)
32. Occupation type
33. National Statistics Socio-economic Classification (NS-SEC) for deceased or mother of deceased juvenile
34. National Statistics Socio-economic Classification (NS-SEC) for husband or father of deceased juvenile
35. 2010 Standard Occupation Classification of deceased or mother of deceased juvenile
36. 2010 Standard Occupation Classification of husband or father of deceased juvenile
37. Retired indicator for deceased or mother
38. Retired indicator for husband or father
39. Place of birth text (for deceased)
40. Country code of place of birth of deceased
41. Government Office Region code of usual residence of deceased
42. Upper tier Local Authority code of usual residence
43. County code of usual residence of deceased
44. County district code of usual residence of deceased
45. Clinical commissioning group code of usual residence of deceased
46. Lower super output area of usual residence of deceased
47. Ward code of usual residence of deceased
48. Name of coroner
49. Coroner's area where inquest has been held
50. Date of inquest text
51. Nature of injury code where the underlying cause of death (ICD10U) is an external cause (secondary cause code)
52. Cause of death row positions 1 to 8

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