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Health, Social Care and Sport Committee
HSCS(5)-20-18 Papur 2 / Paper 2

Submission to the National Assembly for Wales' Health, Social Care and Sport Committee by the National Confidential Inquiry into Suicide and Safety in Mental Health

Executive summary

- Suicide prevention requires a joint approach by public health and mental health services, working with other agencies including primary care, social care, the justice system and the voluntary sector. Our work is primarily on suicide prevention in specialist mental health care but we also conduct studies in other clinical settings and in the general population including those not in contact with services.
- The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) holds a UK-wide dataset of people who have died by suicide who were current or recent mental health patients. The dataset for Wales currently stands at over 1,500 patient suicides.
- There are approximately 75 patient suicides per year in Wales. Current areas of concern include: rising suicides by middle-aged male patients; and services for alcohol and drug misuse.
- We have shown an association between specific clinical initiatives and decreased patient suicide rates - these should be adopted by all health boards. They are: removal of ward ligature points; early follow-up on hospital discharge; 24 hour crisis teams; services for patients with both mental illness and substance misuse; outreach teams for patients who may disengage; implementation of NICE guidance for depression.
- We have also shown lower patient suicide rates linked to organisational factors such as reduced staff turnover and, as a marker of a learning culture, case review involving the family following patient suicide.
- The time of highest risk is during and soon after in-patient care. Following discharge from hospital the peak risk of suicide occurs on day 3, showing the need for early follow-up and care planning at the time of discharge.
- The most common type of drug taken in fatal overdose by mental health patients is opiates. We support further measures to improve safe prescribing of these drugs and antidepressants.
- Our findings show us that there are few differences in suicide risk factors between Wales and England, specifically, and between Wales and the UK as a whole.
- However there are some differences in patient characteristics such as slightly higher levels of alcohol and drug misuse (but lower compared to Scotland and Northern Ireland), and fewer suicides by patients under crisis resolution/home treatment (CRHT) teams.

- Our recent study of suicide by children and young people has highlighted common themes including exam stress, bullying, and bereavement, especially by suicide. Suicide-related internet use was common. Around half have previously self-harmed. Our findings highlight the shared role in suicide prevention among front-line services and agencies, including mental health, social care, youth justice, and education.
- Our recent report on safer care for patients with personality disorder has shown that patients with personality who die by suicide are not receiving care consistent with NICE guidelines.

Introduction

1. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) collects detailed clinical information on patients of mental health services who have died by suicide (and probable suicide) over a 20 year period. NCISH research is based on a UK-wide, comprehensive, internationally unique database; in Wales this currently consists of over 7,000 general population suicides and over 1,500 patient suicides. We provide definitive figures on suicide to clinical services and governments, produce data-driven safety recommendations, and demonstrate that these recommendations reduce suicide. We have addressed safety in:
    - in-patient care including patients under observation, and during post-discharge aftercare
    - specific patient groups, such as those with a diagnosis of personality disorder
    - service settings such as crisis teams, IAPT programmes and substance misuse services
    - patients experiencing particular problems of care such as loss of contact and non-adherence

2. NCISH has been based at the University of Manchester since 1996, and its work in England is currently commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS Wales and other UK funders. The senior academics overseeing NCISH are Professor Louis Appleby, who also chairs the National Suicide Prevention Strategy Advisory Group in England, and Professor Nav Kapur who has chaired the NICE clinical guideline development groups on self-harm and depression.

3. Our core work is therefore on suicide by people under mental health services - we publish annual reports highlighting current concerns. We have also conducted equivalent studies in specific patient groups, such as those with a diagnosis of personality disorder, and undertake studies into suicide prevention in the general population, such as suicide by children and young people. These studies and their implications for prevention are summarised below.

Summary of key NCISH findings

4. Based on data from our most recent annual report,[1] which provides findings relating to people who died by suicide in 2005-2015 across all UK countries – 2015 being the most recent year for which comprehensive data are available, there has been a rise in the number of patient suicides in Wales, specifically in 2012 and 2013. This rise is broadly in line with general population figures.

5. Around 23% of people who die by suicide in Wales are under current or recent specialist mental health care; this figure is the lowest of the four UK nations.

6. The rise in patient suicide appears to be driven by a rise in the number of suicides by male patients, particularly in 2012 and 2013.

7. Over half of the patients who die by suicide have a history of alcohol and/or drug misuse, around 43 deaths per year. However, only a minority (14%) are receiving treatment from drug or alcohol services. During 2005-2015, 59% of patient suicides have a history of either alcohol or drug misuse or both, although this figure is slightly lower in England (54%) and higher in Scotland (69%) and Northern Ireland (71%).

8. 70% of mental health patients have a history of previous self-harm. Our previous studies of self-harm have shown that the subsequent risk of suicide is high and that specialised psychosocial assessment is a key determinant of future risk.

9. The most common methods of suicide by mental health patients are hanging, followed by self-poisoning (overdose). The proportion of suicides by hanging is significantly higher in Wales than in England. The most common type of drug taken in deaths by self-poisoning is opiates.

10. There were 66 suicides by mental health in-patients in 2005-2015; the number fluctuates from 3 to 10 per year. The number of suicides by mental health in-patients is continuing to fall in the UK as a whole but the longstanding downward trend has slowed. Our research has shown an association between specific clinical initiatives, including the removal of ligature points, and fewer in-patient deaths and decreased in-patient suicides rates in implementing health boards.[2] There have been no patients in Wales who died on the ward by hanging reported in the last 3 years (2013-2015).

11. There are around 70 suicides by patients under crisis resolution/home treatment (CRHT) teams, since 2007 there are more patient suicides under CRHT than in in-patient care, reflecting both a change in the nature of care and the importance of reducing suicide in this setting. In Wales, there are proportionally fewer patient suicides under CRHT compared to England but similar proportions compared to Scotland and Northern Ireland.

12. Around 150 suicides occur in the three months after discharge from hospital and the time of highest risk is in the two weeks after leaving hospital. These deaths are linked to short preceding admissions of less than a week and to patient initiated discharge.

13. Almost half of mental health patients have been in contact with services in the week prior to their death, providing a valuable opportunity for prevention.

14. There are few differences in suicide risk factors between Wales and England, specifically, and with the UK as a whole.

Mental health service recommendations

15. Each report we publish carries recommendations to mental health and other services on improving safety. In a series of studies we have examined the features of front-line clinical care and the association with patient suicide rates, monitoring changes over time.[2] We found that NCISH safety recommendations implemented in mental health services were associated with a reduction in the patient suicide rate.

16. The key service features linked to suicide in our studies are listed in Table 1 as "10 ways to improve safety" – these largely reflect recommendations to clinical services but also include organisational characteristics, such as lower staff turnover and multidisciplinary case reviews after serious incidents (in our study, a marker for a learning culture).

Table 1: 10 ways to improve safety
Safer wards - removal of ligature points - reducing absconding - skilled in-patient observation Improved community services - community outreach teams to support patients who may lose contact with conventional services - 24 hour crisis resolution/home treatment teams - care planning and early follow-up on discharge from hospital to community No out of area admissions for acutely ill patients Specialist services for alcohol and drug misuse and patients with "dual diagnosis" Multi-disciplinary case reviews after serious incidents, with input from families Implementing NICE guidance on depression and self-harm Personalised risk management, without routine checklists Lower turnover of non-medical staff

Suicide by children and young people

17. In the general population we have adopted a different methodology to understand suicide prevention in children and young people aged under 25 in the UK, including access to health and other services.[3] In this study we collected data from official sources, including coroners' who take evidence from families, professionals and others, and identified possible sources of stress prior to suicide. The number of suicides at each age rises steadily in the late teens and early 20s and several factors appear to contribute to this (Table 2). There are also a number of groups of young people who die by suicide who have specific risks:
    - Young people who are bereaved, especially by suicide, who would benefit from bereavement support services being widely available;
    - Students in universities and colleges who would benefit from a greater focus on mental health;
    - Looked after children, who need stable accommodation on leaving care and access to mental health care; and
    - LGBT groups.

Table 2: Ten common themes in suicide by children and young people
Family factors such as mental illness and domestic violence
Abuse and neglect
Bereavement and experience of suicide in family or friends
Bullying, including on-line bullying
Suicide-related internet use, e.g. searching for suicide methods, postings on social media
Academic pressures, especially related to exams
Social isolation or withdrawal
Physical health conditions that may have social impact, especially acne and asthma
Alcohol and illicit drugs
Mental ill health, self-harm and suicidal ideas

18. The circumstances that lead to suicide in children and young people often appear to follow a pattern of cumulative risk, with traumatic experiences in early life (e.g. a background of family adversity,

abuse, bullying), a buildup of adversity and high risk behaviours (e.g. unemployment, substance misuse, a diagnosis of mental illness), and a "final straw" event, often a broken relationship or exam stress.

19. Around half of young people aged under 25 who die by suicide have previously self-harmed and self-harm in young people is often accompanied with excessive alcohol and illicit drug use. Self-harm is a crucial indicator of risk and should always be taken seriously, even when the physical harm is minor. Services which respond to self-harm are key to suicide prevention, and should work with services for alcohol and drug misuse, as both are linked to subsequent suicide.

20. The wide range of antecedents found in this study highlight the shared role in suicide prevention among front-line services and agencies, including mental health, social care, youth justice, and education.

Safer care for patients with a diagnosis of personality disorder

21. We have examined the characteristics of patients with a diagnosis of personality disorder prior to suicide.[4] This is a vulnerable group who are at high risk of suicide and self-harm but are sometimes offered little support by health and other services. There are around 150 patients with this diagnosis who die by suicide per year in the UK. The most common method of suicide is self-poisoning, and psychotropic medication is used in a fifth of these deaths; medication which has often been prescribed to the patient in the previous year. The majority of patients have previously self-harmed and alcohol and drug misuse, or both, is common. These findings highlight the importance of safe prescribing in mental health services and primary care, and that the risk in personality disorder is linked to coexisting alcohol and drug misuse, showing the need for substance misuse services to be available.

22. In this study we also asked patients and staff about their experiences of services, and how they thought services might be improved. The findings suggest: (i) patients with personality disorder who die by suicide are not receiving care consistent with NICE guidelines; (ii) there is no clear care pathway to meet the needs of patients with a diagnosis of personality disorder, and there is a lack of support and treatment for patients who do not meet the criteria for specialist services, and (iii) the practice of applying a diagnosis of personality disorder may be stigmatizing and obscure individual needs and working with patients to understand their experiences would be more beneficial.

Summary of key measures

23. There is a substantial amount of evidence on suicide and suicide prevention from our research and other academic units in the UK. On the basis of this evidence, we believe that local authorities and the NHS in every part of the country should develop a joint strategy for suicide prevention. This should include:
    - specific measures to reduce suicide risk in men, particularly in middle age, including services that are available on-line and in non-clinical settings
    - high quality services for self-harm, ensuring psychosocial assessment and follow-up
    - safer mental health care, as described above (Table 1), with an emphasis on crisis teams and care following hospital discharge
    - specialist services for people with drug or alcohol misuse and those with both mental illness and substance misuse
    - measures to reduce isolation for people at risk, including community-based supports and transport links
    - a multi-agency approach to young people's mental health, including self-harm care, CAMHS, primary care, social care, schools and youth justice
    - a system of reviewing and learning from suicide deaths, with input from the family of the person who has died.

References

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