Betsi Cadwaladr University Health Board Response to Welsh Assembly Committee call for evidence on Suicide Prevention

1/ The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour

In 2015, 64 people died by suicide in North Wales. Suicide is one of the leading causes of preventable death and is the biggest killer of men under 50 years in Wales and England (ONS, 2015).

In the background to the suicide and self-harm prevention strategic plan for North Wales, we present a range of suicide data in order to quantify the burden of suicide in the region.

Figure 1 shows how rates of suicide in Betsi Cadwaladr University Health Board (BCUHB) compare to Wales rates over time. Suicide rates are presented as number of deaths per 100,000 people of all ages, and are given as five-year averages to 'smooth out' variations in the data given the relatively small number of deaths each year. It can be seen that the suicide rate in BCUHB was higher than the Welsh average between 2002-2006 and 2008-2012, but in 2009-2013, it crossed over and became lower than the Welsh average.

Figure 1: BCUHB and Wales

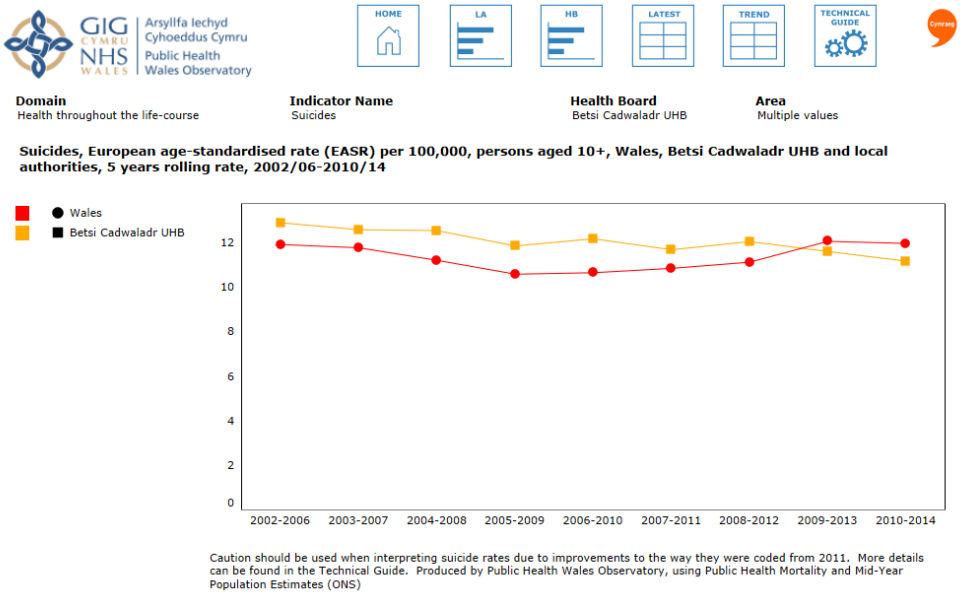


Figure 2 shows the rate of suicide in BCUHB in recent years (the five calendar years 2010-14) is not statistically significantly different from the Wales rate as a whole. In terms of the individual Unitary Authorities (UAs), Figure 3 shows that none of the North Wales UAs are statistically significantly different from the Welsh average.

Figure 2:

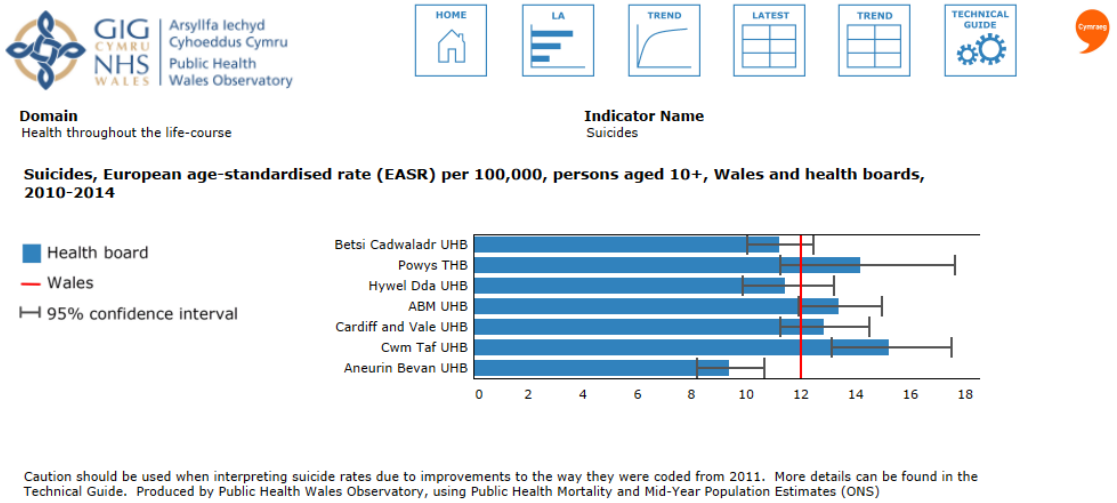
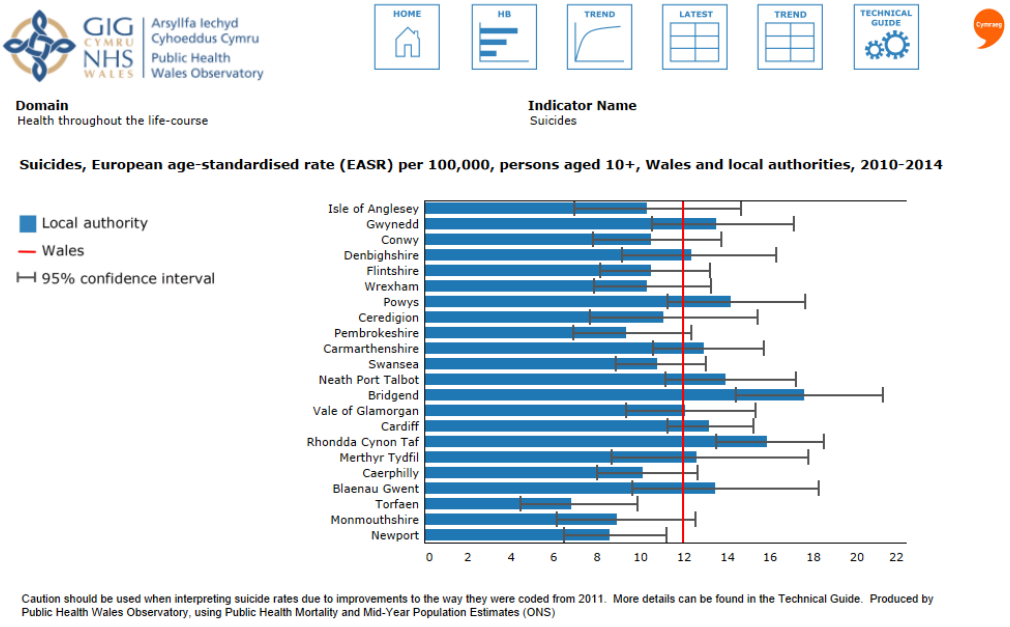


Figure 3:



The overall rate of suicide for all persons hides considerable differences between the rates for men and women in Wales. Male suicide rates are nearly three times higher than female rates, and this has been a consistent pattern. The latest data for 2014 gives a rate of 11.1 deaths by suicide per 100,000 men, and for women the rate is 4.4 per 100,000 in Wales (Appleby et al, 2016). The gender differences in suicide are important and need to be considered. There have been suggestions that this is due in part to the changing nature of society but records suggest that across England male suicides have

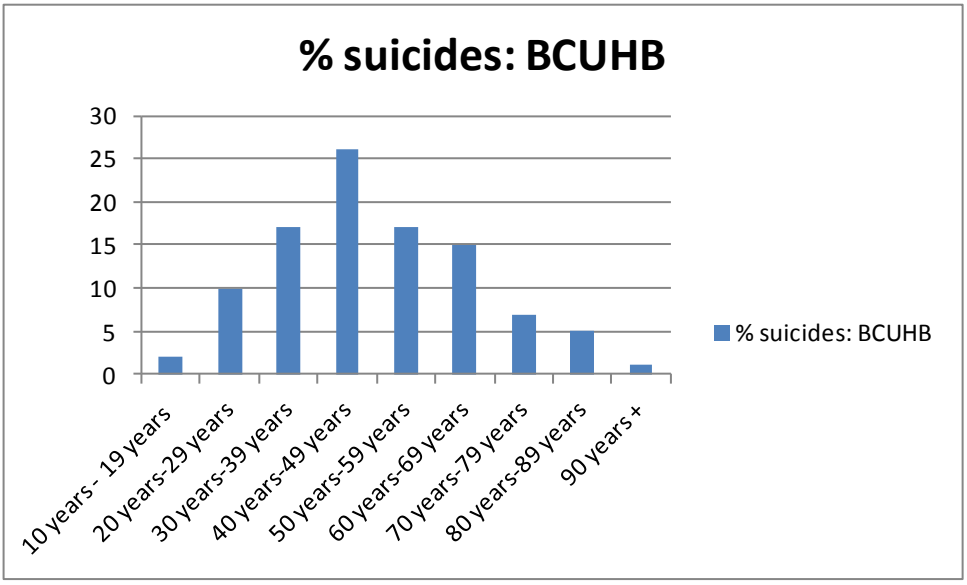
been considerably higher than female suicides since the 1860s, with the male to female ratio fluctuating from 4:1 in the 1880s to 1.5:1 in the 1960s (Thomas & Gunnell, 2010).

As part of the preparation in writing this strategic action plan, the BCUHB Public Health Directorate carried out a 'suicide audit' which reviewed ONS data on 741 suicides that were registered between 2006 and 2015 (calendar years) and occurred in BCUHB or were by BCUHB residents elsewhere in the UK. This was compiled using the strict ONS classification for suicide.

In North Wales over the registration period 2006 and 2015 (calendar years), 580 recorded suicides out of 741 (78%) were in males and 162 in females (22%) (Source: ONS).

Suicide also varies with age. Figure 4 shows the age distribution of the 741 suicides (Source: ONS). It can be seen that the greatest proportion is in those aged 40-49 years.

Figure 4:

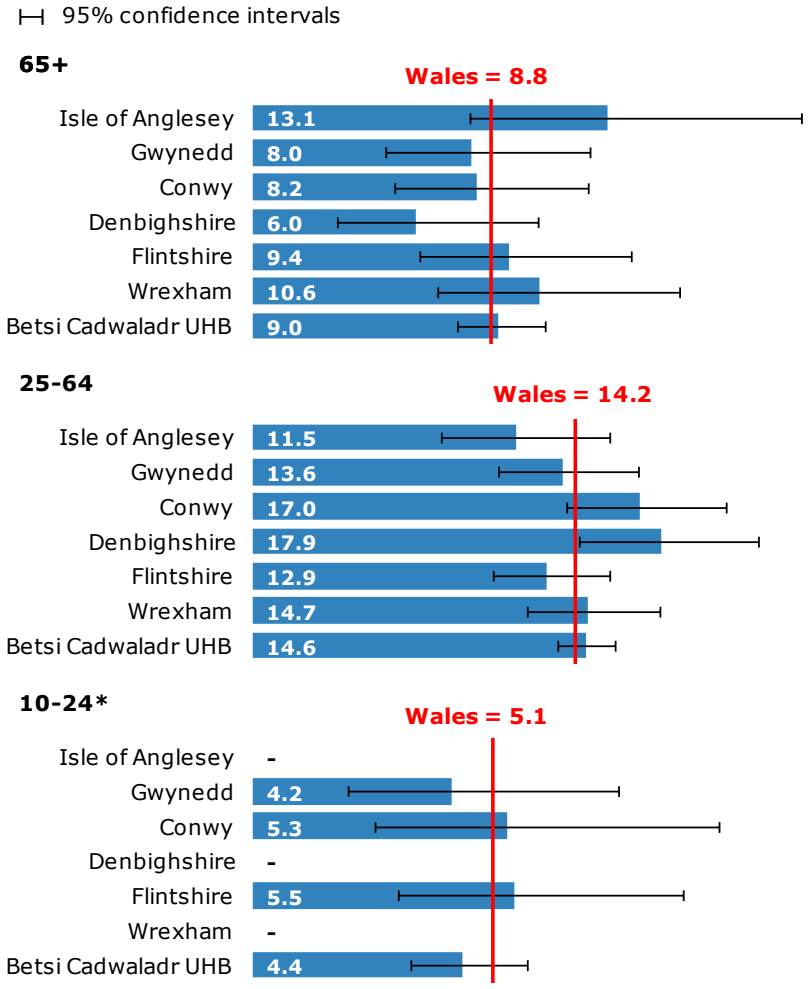


Source: ONS

Rates of suicide also vary with age in BCUHB and across Wales. Figure 5 shows that the rate of death by suicide climbs from a relatively low rate of deaths in young people aged 10-24 and peaks in the age band 25-64. There are no statistical differences between the UAs in North Wales.

Figure 5

Suicides, age-specific rate per 100,000, persons aged 10 & over, Betsi Cadwaladr UHB and Wales, 2005-14
Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



* Following a definition change in 2016, deaths in children aged 10-14 are considered suicides if the ICD-10 code was X60-X84 intentional self-harm. Rates have been suppressed where there were counts of less than 10.

Risk factors for suicide include male gender, those aged 35 – 49 years, a recent history of self-harm, people in the care of mental health services, being transgender, those with one or more long term physical health conditions, a family history of suicide, a history of childhood abuse and trauma, redundancy and living with material deprivation, those with relationship problems and people in contact with the criminal justice system. However, this list is not exhaustive.

There is a regular review of suicide by people known to mental health services - the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. The Inquiry report refers to 'patient suicides' as those that occur within 12 months of mental health service contact. The most recent report (Appleby et al, 2016) covers the period 2004-2014. This reported that across Wales, 23% of all suicides were identified as patient suicides; in total there were 63 in-patient deaths by suicide in Wales in 2004-2014, an average of 6 per year. There was an increase in the number of patient suicides between 2004 and 2013 with a large rise in 2012 and 2013. The most common methods

of suicide by patients were hanging (47%), self-poisoning (24%) and jumping (10%). The most common primary diagnoses were affective disorders (42%), schizophrenia (16%) and alcohol dependence/misuse (10%).

At least half of people who die by suicide have a history of self-harm, and one in four have been treated for self-harm in hospital in the past year (Department of Health, 2012). The risk of suicide is highest in people who repeatedly self-harm and who have used violent or dangerous methods.

Research has shown that nurses, doctors, farmers/agricultural workers and veterinary workers are all at higher risk of suicide which may be related to their ready access to the means of suicide and knowledge of how to use them (Department of Health, 2012). In the UK, the suicide rate between 2011 and 2015 for all female health care professionals was higher than national average (ONS, 2017). Suicide rates for female doctors have been historically higher than the national average for females. In contrast the rates of suicide for male doctors were 37% lower than the male average (ONS, 2017).

North Wales has a significant population of seasonal workers due to the tourist industry and males working in the lowest-skilled occupations have a 44% higher risk of suicide than the male national average; the risk among males in skilled trades is 35% higher. Additionally, the risk of suicide among low-skilled male labourers, particularly those working in construction roles, is 3 times higher than the male national average (ONS, 2017).

Military veterans are another occupational group at risk. Kapur et al (2009) analysed the demographic data of 224 veterans who had died by suicide between 1996 and 2005. The risk of suicide was greatest for males, those who had served in the army, those with a short length of service, and those of lower rank. Although the overall rate of suicide was no greater than in the general population, the risk of suicide in male veterans aged 24 years and younger was about two to three times higher than the risk for the same age group in the general population. Importantly, the rate of contact with specialist mental health was lowest in the age groups at greatest risk of suicide, suggesting that needs are not being met. The reasons behind this population's vulnerability to suicide are not clear, but the researchers suggested that this might include:

- Finding the transition back to civilian life more difficult
- Being adversely affected by service-related experiences
- Having a pre-service vulnerability which has not been addressed

With males in this age group known to be particularly reluctant to seek help, as well as the fact that they may not even identify themselves as veterans, this sub-group may be particularly vulnerable. Fear et al (2010) backed up these findings by reporting that the overall suicide rate is no higher in UK ex-service personnel than it is in the UK general population; ex-service men aged 24 years or younger are, however, at an increased risk relative to those in the general population of the same age.

People in contact with the criminal justice system also have a higher risk of suicide than the general population (Suffolk CC, 2016). People are at highest risk in their first week

of imprisonment. North Wales has one new prison (HMP Berwyn) and fortunately there have not been any deaths by suicide since it opened. No data was available for suicide in other forms of custody in North Wales. Prison health, including mental health, is the responsibility of BCUHB.

It is widely recognised that other factors and life experiences may place individuals at higher risk of suicide. These can include: chronic pain or disability; job loss and unemployment leading to socio-economic disadvantage; family breakdown and relationship conflict, financial difficulties, and social isolation (Suffolk CC, 2016).

Living with a long term physical health condition, including cancer, heart failure, HIV/Aids, Traumatic Brain Injury, COPD, chronic pain, renal disease, diabetes, and sleep disorders, is associated with higher risk of suicide (Ahmed et al, 2017).

Alcohol or drug abuse is strongly associated with suicide risk, particularly in individuals who also experience poor mental health (known as dual diagnosis).

Other groups of people who may have higher rates of mental ill-health (although detailed data on suicide rates is lacking) include survivors of abuse or violence, members of minority ethnic groups, and children who are especially vulnerable such as looked after children, care leavers, and children in the youth justice system. It is also recognised that members of the LGBT+ community are at increased risk of suicide (Department of Health, 2012).

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after birth. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. Suicide is a leading cause of death for women during pregnancy and in the year after giving birth (MBRRACE-UK, 2015).

Adverse childhood experiences (ACEs), including exposure to child abuse and neglect, are well documented risk factors for suicidality (Ports et al, 2017). Cymru Well Wales has committed to addressing ACEs and their impact in Wales by making all public services in Wales able to respond effectively to prevent and mitigate the harms from ACEs, and by building protective factors and resilience in the population to cope with ACEs that cannot be prevented.

2/ The social and economic impact of suicide.

The family and friends of someone who dies by suicide are at increased risk of poor mental health and emotional distress. Partners bereaved by suicide are at an increased risk of suicide themselves, as are mothers who lose an adult child to suicide. Children bereaved by a parent's suicide are at increased risk of depression, alcohol or drug misuse, Post Traumatic Stress Disorder, and their own risk of suicide is increased (Penny and Stubbs, 2015; Pitman et al 2014). These risks are additional to the risks associated with bereavement from non-suicide deaths. The evidence suggests that specialist bereavement counselling and support can be helpful for people, although the efficacy has not been well demonstrated to date (Department of Health, 2012).

Furthermore, every death has a ripple effect within families and communities, resulting in the lives of at least ten others being seriously affected to the extent that they are likely to find it difficult to work, to form relationships and live life to their full potential.

Suicide is a significant equality issue as there are marked differences in the suicide rates according to people's socio-economic backgrounds (John, Glendenning & Price, 2017). *Talk to Me 2* highlights that improving the mental health of people who are vulnerable due to these circumstances supports suicide prevention.

The economic cost of each death by suicide for those of working age is estimated to be £1.67 million at 2009 prices (John, Glendenning & Price, 2017). This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering. It is estimated that at least ten people are ultimately affected by every suicide.

If we assume that 85% of the 64 suicides (=54) that occurred in BCUHB in 2015 are of working age, this means a potential cost to North Wales of about £90m per annum. If an area-wide suicide prevention intervention were to achieve only a modest 1% reduction rate in the number of suicides, there would be a saving of almost £1m per annum.

3/ The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide

The Welsh Government Strategy *Talk to Me 2*, sets out the strategic aims and objectives to reduce suicide and self-harm in Wales over the period 2015-2020. It identifies priority care providers to deliver action in priority locations to the benefit of key priority groups, and confirms the national and local action required. The six main objectives of *Talk to Me 2* are:

- Improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come into contact with people at risk of suicide and self-harm and professionals in Wales
- To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm
- Information and support for those bereaved or affected by suicide and self-harm
- Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
- Reduce access to the means of suicide
- Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action

Some of the priority groups that the strategy targets include: men in mid-life; older people over 75 years with depression and co-morbid physical illness; children and

young people with a background of vulnerability; people in mental health services; people with a history of self-harm; priority care providers; police; firemen; Welsh Ambulance staff; primary care workers; emergency department staff.

Some of the priority places and settings that the strategy targets include: hospitals, prisons, police custody suites; workplaces, schools, further and higher education establishments, primary care facilities, emergency departments, rural areas and deprived areas.

We believe that *Talk to Me 2* has proven effective on the ground, with the aims and objectives of the North Wales Suicide and Self-harm prevention strategic plan mirroring the aims and objectives of the Welsh Government Strategy.

The North Wales Suicide and Self-Harm Prevention Group has an active multi-sector and multidisciplinary membership who collaborate very effectively. Recently they led a number of local North Wales public awareness campaigns in collaboration with the Health Board. They worked with the Mental Health Head of Communications on a campaign targeted at educating the public about the Netfix series "13 Reasons Why." In July 2017 the Health Board published a 1 min YouTube clip to help educate the public about the '13 Reasons Why' and how concerned adults should safely respond and how young people seek help if needed. The video and information was also shared on the BCUHB and CALL Helpline websites and Facebook pages, via their Twitter feed and was featured in the main North Wales online news outlets and news papers including: Wales online, Daily Post, Cambrian News (Dwyfor and Meirionnydd weekly paper) and North Wales Chronicle, Rhyl Prestatyn and Abergele journal, News North Wales. In addition to covering the issues around '13 Reasons Why', the articles also included public awareness messages around suicide prevention. The features also promoted the importance of help seeking, the basics of making a safety plan and included a link to an online resource written for people in distress which included guidance on how to get through tough times, who to contact and how to make a simple safety plan.

The North Wales Suicide and Self-harm prevention group has also been working hard to reduce access to the means of suicide, especially regarding the Menai Bridge, which is a high frequency location for suicide. A number of Samaritans signs have now been erected on the bridge, as well as work to install 4 phones connected directly to the Samaritans on both sides of carriageway and at each end of bridge. There have also been early discussions around the installation of thermal imaging cameras. An alert could be sent to police control centre or other organisation if someone lingers for too long, especially at dusk/dark. There is a feasibility study underway regarding installation of higher barriers on the bridge, an evidence based intervention. There have also been initial discussions with the operators of the Pontcysyllte Aqueduct, another high frequency location for suicide.

4/ The contribution of the range of public services to suicide prevention, and mental health services in particular.

Suicide and self-harm prevention requires a multi-sectoral approach to ensure joint working across a range of settings. A wide range of public services need to be involved

including: NHS, Local Authorities, Fire Service, Coroner and Police. All these agencies are around the table as part of the North Wales Suicide and Self-harm Prevention Group. Mental health services also play a key role in the North Wales Suicide and Self-harm prevention group and feature strongly in the implementation of the new strategic plan in North Wales.

People take their own lives because the distress of living becomes too great or illness or other personal circumstances seem intolerable**.** Suicide is preventable, but a significant culture change is needed. To this end the Health Board recently ran a Suicide Awareness and Suicide Response training day for 100 cross-sector, multidisciplinary professionals which was extremely well received. The training programme supports the development of a common language and approach, promoting a consistent assessment and documentation of the process, and a more integrated response across statutory services, third sector providers and communities. The training included a suite of clinical frameworks, some of which have been adapted for non mental health settings, including primary care, third sector, education, and the police.

5/ The contribution of local communities and civil society to suicide prevention.

The Third Sector, as well as local communities, need to be involved in the design of suicide prevention interventions through the principle of co-production. In the development of the North Wales Suicide and Self-harm Prevention Strategic Plan, we cooperated very closely with organisations such as Caniad, who are the combined voice for mental health and substance misuse involvement in North Wales.

Responsibility for people with suicidal thoughts has traditionally been seen to lie with specialist mental health services and many people feel ill equipped to respond. However early intervention from a relative, friend, colleague or compassionate care giver could make a real difference to saving lives. Suicidal people are often ambivalent about dying, and their lives can be saved right up until the final moment.

We need to move away from a pre-occupation with a ‘risk assessment’ process of characterising, quantifying and managing suicide risk, towards a greater focus on intervention based on compassion, safeguarding and safety planning.

Everyone in society has a role to play in the prevention of suicide and self-harm. Every person experiencing suicidal thoughts and/or self-harming, should be taken seriously and supported to co-produce a safety plan, with strategies, contacts for support and explicit reference to the removal or mitigation of access to lethal means.

Equipping people to respond safely and effectively to someone at risk of suicide, is itself an emotional journey, as well as a process of developing the right attitudes, knowledge, skills and confidence.

The BCUHB Self-Care Team has been delivering Emotional Resilience training across North Wales to members of the community, patients, carers and staff.

Third Sector services are available when statutory services are not available such as out of office hours and at weekends. Samaritans branches in Bangor, Rhyl, Aberystwyth, Llandrindod Wells, Newport, Bridgend, Cardiff, Swansea, Haverford West (Chester branch plays an active role in North East Wales and Wrexham) provide 24-hour phone, text and email help line service for those in despair and who have suicidal thoughts. Many branches also offer people the opportunity to talk face to face. Bridgend branch pioneered "Feet on the Streets" to provide support for those on Friday and Saturday evenings in town, when the night is not working out very well.

Two specific projects that Samaritans have been involved in include: Network Rail project – Samaritans have trained network rail staff to enter into conversation with those who do not catch a train or look distressed along the rail network; Small talk Saves Lives campaign – encouraging general public to talk to people who appear upset on rail network.

We believe that Third Sector "Drop Ins" and other services that are provided across North Wales are invaluable as they provide an informal & safe place for people to get the support (often peer support) that they need to prevent their suicidal thoughts escalating. This support could come from a mental health specific organisation e.g. Mind, or from a community group such as a church group. Lots of this informal support happens on a daily basis, but it is not necessarily known about by the wider community. Many organisations also get calls for help from people and although this is probably recorded internally, this is not necessarily recorded or collated elsewhere. Certain counties across North Wales have local suicide prevention groups in which third sector organisations play an active part.

6/ Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.

The Welsh Government strategy, *Together for Mental Health*, shows the importance of ownership of mental wellbeing as a multi-sectoral issue.

There are issues which have been highlighted around having the data to understand where we can have an impact in terms of suicide and self-harm and how this translates to regional and local improvement and implementation. We would therefore call for increased resource to improve data in this area.

From a Child and Adolescent Mental Health Service (CAMHS) perspective, we have seen the number of cases admitted to paediatric wards increase dramatically over the past 5 years, to the point where in North Wales we have a dedicated team of CAMHS clinicians based on the paediatric ward in order to deal with the work of assessing these young people. We tend to see an increase in admissions due to self-harm around the time of exams, and there seems to be a correlation between stress experienced at school and acts of self-harm.

CAMHS also feels that bullying is an important factor in mental ill health amongst young people, be it online bullying or face to face. Bullying appears to be a factor in many presentations (anxiety, depression, OCD), not just self-harming and para-suicidal behaviour.

We would welcome the government's continued support in putting more emotional health workers into schools, so that young people can access help to regulate their emotions before they consider engaging in self harming and suicidal behaviour. A national anti-bullying programme (such as Kiva) in all schools would help to decrease the number of referrals made into specialist services such as CAMHS.

We have welcomed the Adverse Childhood Experiences educational programme, and agree that it is so important for the public and for health professionals to be aware of the effects of ACE's on a person's life. As a team of professionals we feel that it is highly important for school children to be educated about the importance of stability in the first 1000 days of life and how instability at this time can be a very important factor in the development of severe mental health problems later on in life. We also recognise that during this period (first 1000 days of life) the foundation for emotion empathy and good social skills is formed: skills which increase resilience to adverse life experiences, and thus resilience to developing mental health problems.

Lack of bereavement counselling has been identified as a concern locally and whether there are links to self-harming.

7/ Innovative approaches to suicide prevention.

In the WHO 2014 report 'Preventing suicide: A global imperative' Dr Margaret Chan, Director-General World Health Organization encourages the view that suicide is preventable (WHO 2014). Encouraging help-seeking behaviour, rapid access to effective

treatments, hopefulness, identifying reasons for living, and removal of access to means can contribute to suicide prevention. Suicide is also rare event and we must keep this in perspective.

There are a number of innovative approaches to suicide prevention – but these need to be based on evidence of what works. The Public Health Wales Observatory Evidence Service has produced an evidence map to inform the development of local suicide and self-harm prevention plans in Wales (Public Health Wales Observatory, 2017). It summarises research evidence that addresses the question: "What interventions might be effective in reducing rates of suicide, self-harm and suicide ideation in Wales"? Included sources were limited to NICE and NICE accredited guidelines and systematic reviews produced using a robust methodology adhering to systematic review principles. Sources have not been critically appraised by the evidence service. Where evidence included in NICE guidance was duplicated in retrieved systematic reviews only the NICE guidance has been included. Some additional sources that may be useful in informing the development of local suicide prevention plans have also been included. These include high level sources such as published systematic reviews or evidence syntheses/statements/guidelines from recognised (e.g. expert body) sources.

The evidence map covers:

- Primary prevention
- Screening and assessment tools
- Management of self-harm and suicide
- Mental healthcare
- Specific populations
- Others

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