Understanding suicide and suicide rates in ABUHB: Systemic Learning

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Understanding sudden and unexpected deaths (SUDS)

- The Health Board has various means of noticing and understanding SUDs
- SUDS are identified and reported in the Health Board through direct reports, reports from partners and alerts from the Coroner
- Suicide – there are a number of factors that determine whether a SUD is classified as suicide and this can often take some time
- NCISH – allows benchmarking and provides national thematic learning
- Newer developments
    - RTSSS: Deaths by suspected suicide are reported to Public Health Wales before a coroner's inquest. It is anticipated that the number of deaths by suspected suicide may be higher than the number of suicides as determined by a Coroner, as some deaths by suspected suicide may be found to have a different cause following a Coroner's investigation and inquest.

Suicide amongst those accessing mental health and learning disabilities services

- The Mental Health and Learning Disabilities Division provides a range of services including Crisis Prevention services (e.g. 111 Press 2), Primary Care Mental Health Support services, Secondary care services (Mental Health and Learning Disabilities) and specialist services (e.g. Specialist Drug and Alcohol services, Veterans services, Liaison services and Forensic services). Services are provided for all adults from the age of 18 upwards. Services for children are provided by a separate Division.
- All unexpected deaths of people known currently or in the last 12 months to Mental Health services are reported as a Serious Incident.
- All unexpected deaths are treated as an SUI (this includes death by physical health causes)
- All SUIs are subjected to scrutiny and learning
- Case-based learning and thematic learning
- In relation to suicide, as there can often be a delay in terms of a conclusive verdict, we are therefore likely to over-estimate the incidence of suicide

Data from RTSS (up to Jan 2024)

- From 1 April 2022 – 31 March 2023 there were 356 deaths by suspected suicide of Welsh residents who died in or outside of Wales, giving a rate of 12.6 per 100,000 people.
- Males accounted for 78% of deaths by suspected suicide. The age-specific rate was highest in males aged 35-44 years (29.4 per 100,000), followed by males aged 25-34 years (29.2 per 100,000).
- By regional area of residence, Mid and West Wales had the highest rate of death by suspected suicide (15.7 per 100,000), which was statistically significantly different to the all-Wales rate and with North Wales and South-East Wales.

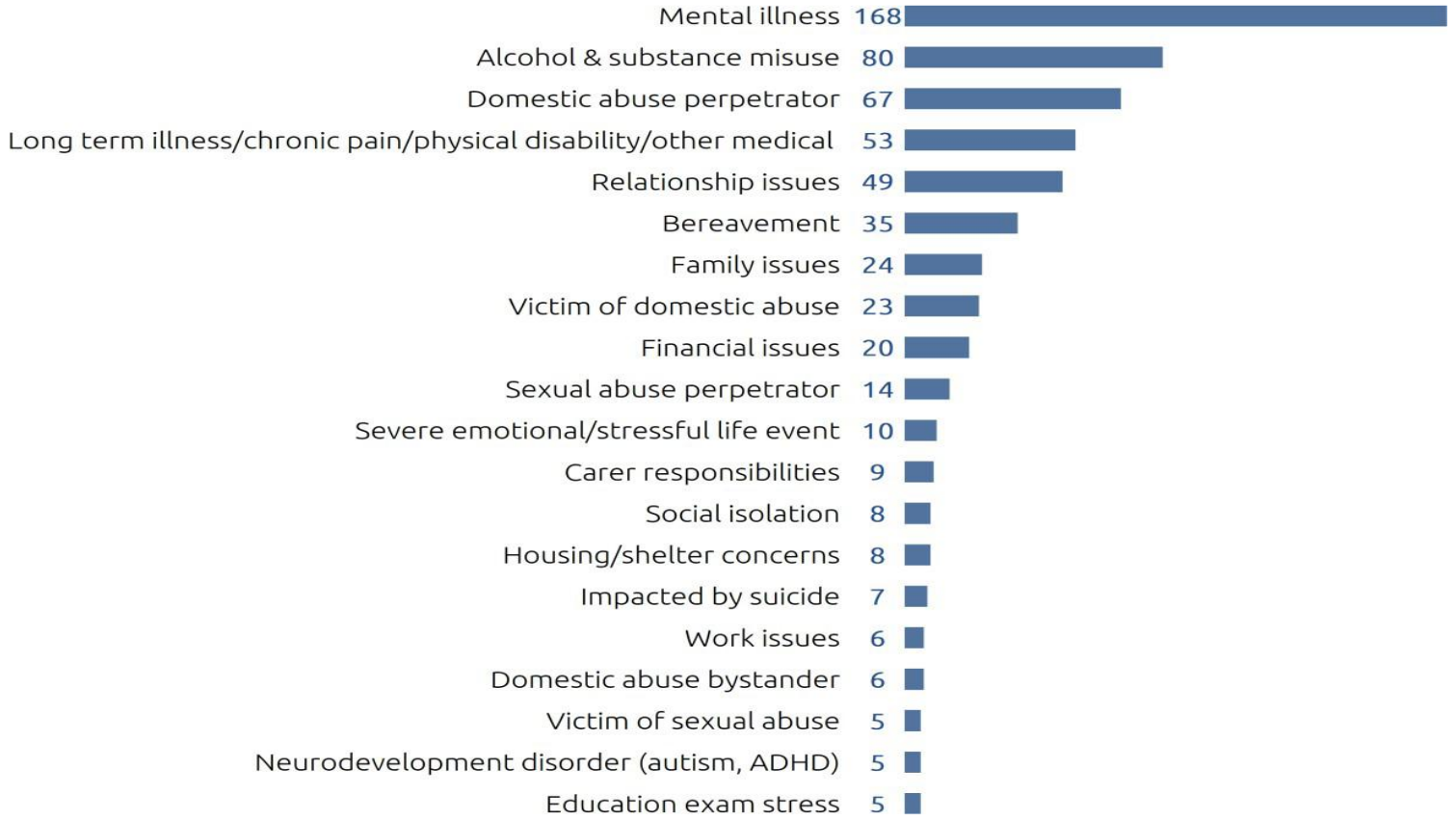
<u>Social factors:</u>

- The rates of deaths by suspected suicide in residents in the most deprived and next most deprived areas (13.9 per 100,000 and 13.7 per 100,000) were statistically significantly higher than the rate in residents in the least deprived areas (9.5 per 100,000).
- The rate of deaths by suspected suicide in people who were reported to be unemployed was 114.1 per 100,000, which was at least 12 times higher than in any other employment status group.
- 74% of the deaths by suspected suicide were in people previously known to the police.

Some other key features

- ABUHB not an outlier in RTSSS either in terms of variance from the All Wales rate or from being statistically significantly different from any other HB
- ‘Mental illness’ was a factor cited in 47% of those dying by suicide
- Alcohol and drugs – 22%
- Domestic abuse perpetrator 19%
- Long term illness

A representation of the prevalence of specific contributing factors



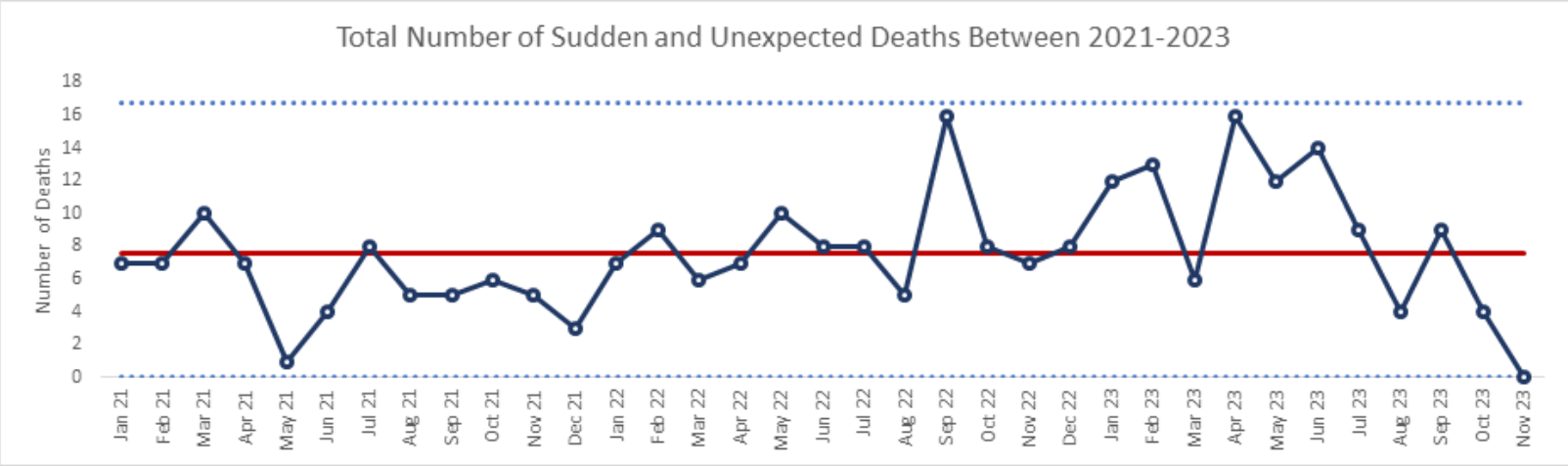
What do we currently know about the local incidence of suicide?

- A focus on data and intelligence held by the Mental health and learning disabilities Division
- Two recent deep dive reviews were conducted to help us consider any local learning
- This learning identified all SUDs in the MH&LD Division and conducted a comprehensive review of the known contributing factors in order to allow us to bring thematic learning, identify any particular hot spots and trends.

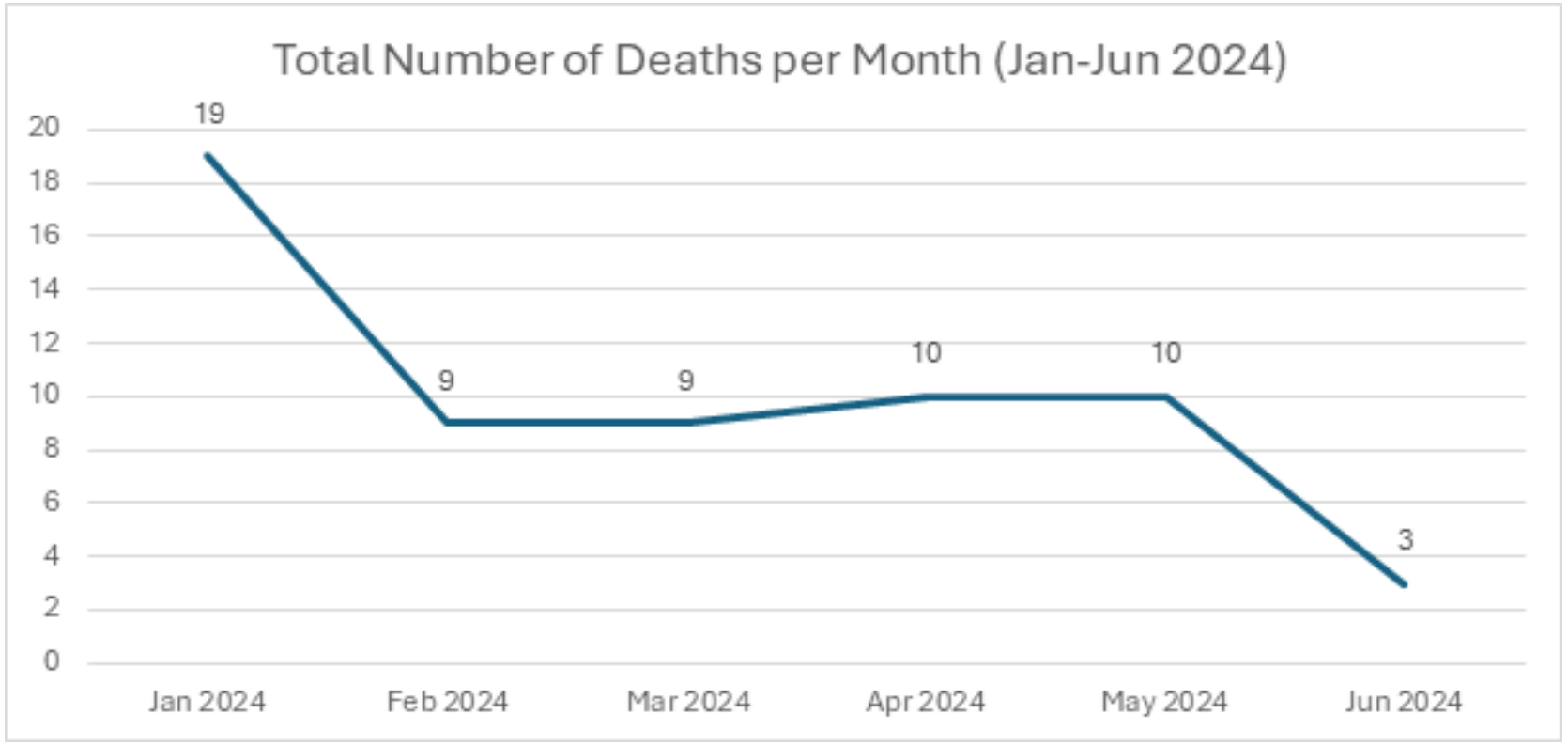
Local Learning

- Studied the period 2021 – 2023 and, more recently Jan – June 2024

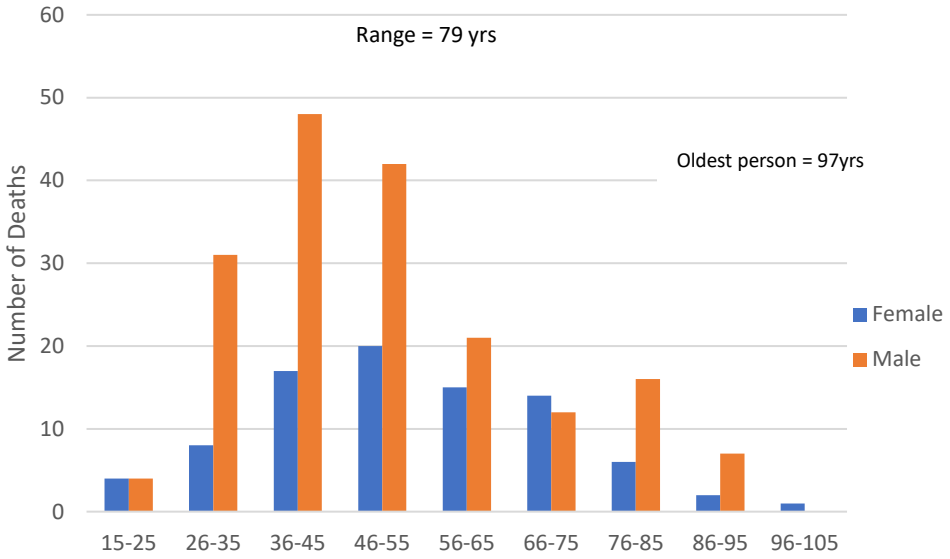
Findings



More Recent Findings (Jan – June 2024)

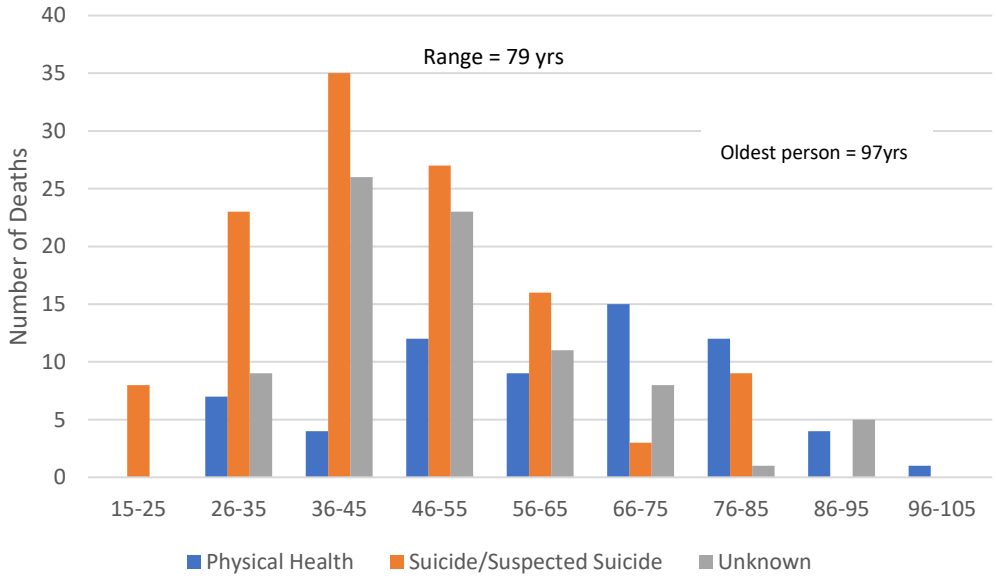


7 of which were suicide/suspected suicide; 33% of these 60 deaths were unclassified/unknown



All deaths by age and sex at birth

Mirrors national trends



Number of deaths by cause of death and age

Note numbers of young people losing their lives

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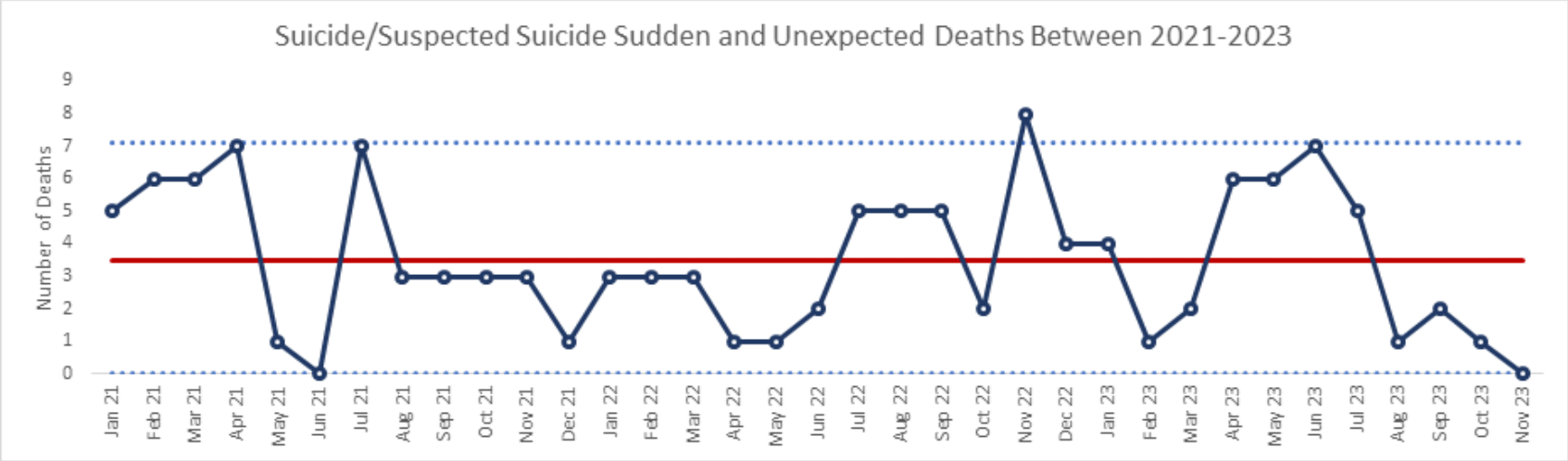
Local data



- No particular trends in terms of months or seasons. Considerable variability from month to month and eyeballing of the clinical data does not help us elucidate any more in terms of factors that may serve to underpin this variability.
- In terms of other clinical trends, local data bears many similarities in terms of demographics, to national data collected through both RTSSS and NCISH. Across all age groups, more men than women die by suicide or suspected suicide. This is significantly more likely in younger men aged 26 – 55 with the starkest contrast between men and women in the 36-45 year category.

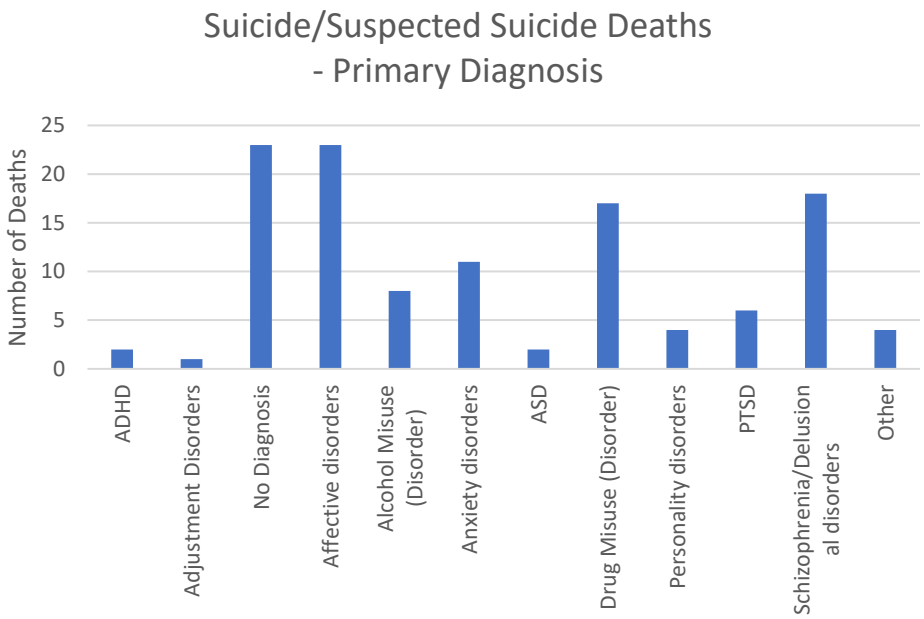
Demographic trends

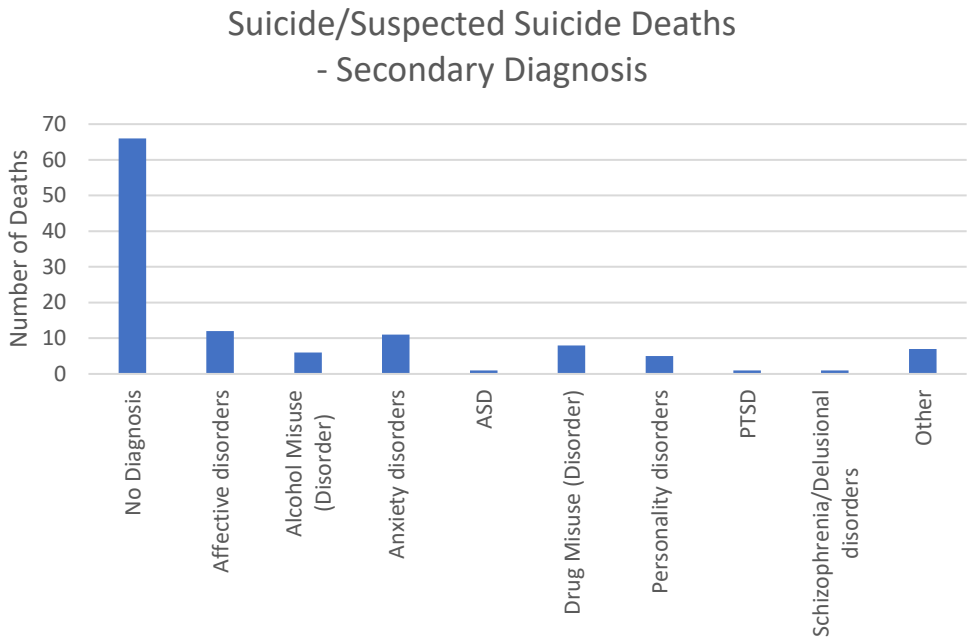
- The vast majority of people (men and women) who die by suicide were not in a relationship according to the electronic patient information system and/or clinical records.

- This data is not particularly reliable as often it would have been collected at the point of access to the service rather than point of death. Furthermore, 44 males and 11 females did not have their relationship status recorded in any data source . In line with the data presented in the RTSSS, the majority of people who die by suicide are economically inactive and not in a relationship or partnership .

- In terms of ethnicity, 64% of those confirmed or suspected to have died by suicide were from white ethnic group. The remaining were unknown/not recorded.

Suicide/suspected suicide & clinical need





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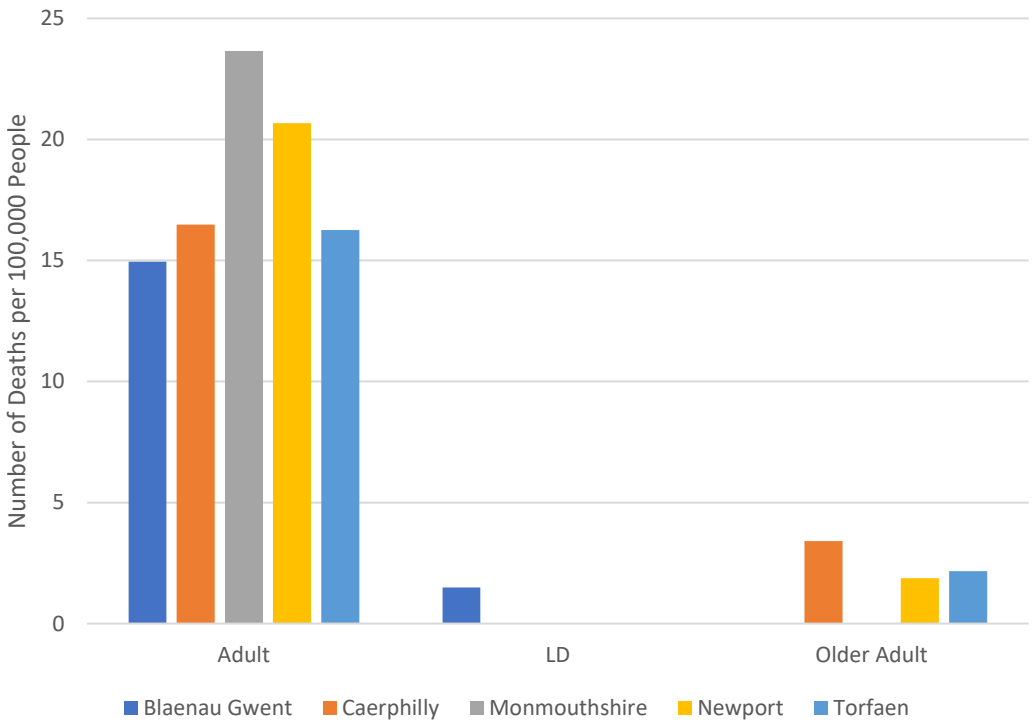
Trends – clinical need

Examination of these charts indicates that there are trends in terms of the diagnostic groups in which suicide was more prevalent during this study period

These include affective disorders, psychotic disorders (including schizophrenia and schizoaffective disorder), and drug disorder or substance use. The later was only coded if it was noted as a formal diagnosis rather than a behavioural pattern identified as part of routine clinical practice (this was recorded separately as a narrative)

Suicide and geographical*



- The preponderance of deaths by suicide occur in people who are known to the Adult Mental Health directorate. This is the Directorate serving the largest population and with the greatest diversity of service provision
- Highest proportionate rate in 2021-2023 study is in Monmouthshire
- This trend was not replicated in the 2024 analysis, although the prevalence of death attributable to physical health causes was higher in Monmouthshire

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* Per 100,000 population

What are we already doing?

- As stated earlier, there is a clear process around recording and investigating SUDs including suicide and suspected suicide. This learning is conducted and reviewed by a full multi-disciplinary team. This reports in to the Health Board Quality and Patient Safety infrastructure and includes the HB mortality group.
- The MH&LD Division can also self-assess against the NCISH toolkit
    - Safer Wards
    - Easy follow-up after discharge from hospital
    - No out-of-area admissions
    - 24 hours crisis support
    - Family involvement
    - Personalised risk management
    - Outreach teams
    - Reducing alcohol and drug use
    - Managing self-harm (psychosocial assessments in place, liaison teams in situ, highly specialist intervention for severe and enduring self-harm)

Further quality improvement measures

- Routinely monitoring depression and providing more robust services for provision of evidence-based care for depression and anxiety
- Improve interface between drug and alcohol and mental health teams
- Reduce variation (COG)
- Evidence based intervention for those with psychosis (outside of EIS window)
- Additional measures for men with mental ill health – it would be helpful for partners to consider community level interventions for men.

Wider health board

- It is important to acknowledge that suicide is not always underpinned by a ‘major mental illness’.
- Suicide can be seen as an act that occurs in the context of stressors that outweigh the person’s ability to cope. Factors that can increase the risk of suicide occur outside of mental health systems and services: complex physical health needs, chronic pain, bullying in schools, social contagion, drug and alcohol services.
- With this in mind, the Health Board has access to interventions designed to enhance coping in multiple specialties including for our own staff who may be at risk as a result of their occupational profile:
  - Alcohol liaison service
  - HART
  - Public Health

Community Resources to be aware of

- 24/7 help in an emotional crisis: 111 press 2
- Papyrus UK Suicide Prevention | Prevention of Young Suicide
- Suicide Prevention Charity | Campaign Against Living Miserably (CALM)
- Staying Safe
- Melo - Mental Health & Wellbeing Resources, Courses & Support
- Samaritans | Every life lost to suicide is a tragedy | Here to listen