Key messages

- Cheshire East has a slightly higher rate of suicide than England. There has been a gradual increase over the last 10 years.
- Men aged 45-64 are most at risk.
- Risk factors for suicide include physical health problems, mental health diagnosis, a previous suicide attempt, relationship problems, alcohol problems, drug misuse, self-harm, domestic violence and bereavement by suicide. For young people under 25, risks also include abuse and neglect, bullying, suicide-related internet use, academic pressures, social isolation, physical health conditions that may have social impact, alcohol and drugs, and suicidal ideation.
- The latest evidence suggests that there is a link between self-harm and suicide.
- Cheshire East is working towards 'Suicide Safer Communities; a multi-disciplinary approach which develops leadership, intelligence, awareness, training, community interventions, clinical interventions, support for those bereaved, evaluation and sustainability.
- Suicide audits identify that many people who die by suicide present to their GP in the months prior to their deaths. The reasons for this have been found to be physical as well as mental illness. This identifies the importance of assessing emotional wellbeing regardless of the primary reason for presentation.
**Needs analysis**

Suicide is defined as deaths given an underlying ICD-10* cause of intentional self-harm or injury/poisoning of undetermined intent. In England, it has been customary to assume that most injuries or poisoning of undetermined intent are cases where the harm was self-inflicted but it cannot be established that the deceased intended to kill themselves. 106 people (81 male, 25 female) took their own lives during the period 2014-2016**, an average of 35 deaths per year. This is slightly above the England average. Suicide rates in Cheshire East have increased gradually since 2002-04, despite remaining stable nationally.

Suicide is a major public health issue and a leading cause of preventable death. It is also a personal tragedy with far-reaching consequences.

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*ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification developed by the World Health Organisation (WHO).

**Suicide mortality is calculated by the year the death was registered. This means that the death may actually have occurred during a previous year.

Source: phoutcomes.info; ONS
Suicide rates in Cheshire East have increased in both males and females in recent years. This increase is not statistically significant, but must still be of concern locally, since all suicides are preventable. Nationally, around 75% of suicides occur in males.

Suicide is the most common cause of death in men under 50. In England and Wales, suicide is the second most common cause of death (following accidents) in males aged 15-19 and 20-24 and accounts for 21% and 26% of deaths respectively. In females aged 15-19 it is the third most common cause of death (following accidents and cancer) and in females aged 20-24 it is the second most common cause of death (after accidents); causing 14% of deaths and 18% of deaths respectively. Locally, there were 7 deaths from suicide in 15-19 year olds and 10 deaths in 20-24 year olds between 2012 and 2016.

Source: phoutcomes.info
Suicide Audit

A suicide audit was undertaken in Cheshire East including all inquests with a suicide, open or narrative verdict from November 1st 2014 to October 31st 2015. 45 cases were audited: 33 suicide verdicts, 7 open verdicts and 5 narrative verdicts*. The results fed into a wider audit covering Cheshire and Merseyside. An audit of cases from 2016 and 2017 will take place in the summer of 2018. This will again feed into a Cheshire and Merseyside Audit.

The main findings of the audit were that 80% of the cases had at least one known risk factor. Method of suicide varied by gender. The most common method for males was hanging/strangulation, accounting for 30% of deaths. The most common method in females was self-poisoning, accounting for 50% of deaths. All deaths caused by jumping/lying before a train, carbon monoxide poisoning, cutting/stabbing and firearms were in the male group. This is consistent with regional and national data.

The pattern regarding location of death is similar to that of the regional audit review. The majority of deaths occurred at home or other accommodation (67%).

The regional audit identified several factors that bear further investigation locally. There were a number of suicides among people from Eastern Europe, which may be relevant to Cheshire East, which has a sizeable Eastern European population particularly in Crewe. The regional audit also highlighted that, where sexuality was recorded, 3% of cases were recorded as being homosexual or bisexual. In addition, 56% were not in current relationships and 30% lived in the most deprived areas nationally.

In terms of risk factors, 38% of cases had had a previous suicide attempt, 30% had relationship problems and 23% had financial problems. 56% of people had a mental health diagnosis recorded.

In the month before death, at least 39% had seen their GP and 24% had been in contact with mental health services. In the year before death, 67% had visited their GP and 37% had been in contact with mental health services.

*An open verdict is recorded where the death is considered to be suspicious but alternative verdicts cannot be proved. Some of these deaths may be suicide but it cannot be proved conclusively that the deceased intended to take their own life.

A narrative verdict is a factual statement of the circumstances surrounding the death without attributing blame to any one individual.
The Real Time Suicide Surveillance System was established across local authorities in Cheshire and Merseyside in September 2017, in order to provide earlier notification of potential suicides to the relevant local authority. The aim of this was two-fold – to ensure a more timely response and to try to prevent further suicides in the form of clusters or contagion.

Between September 2017 and March 2018, there were 22 suspected suicides in Cheshire East. 18 of the victims were male and 4 female. They ranged in age from 17-77, with the average age being 46. Nine of these deaths were due to hanging, three to jumping or lying in front of a train, three to overdose, two to toxicity, two to firearms, one to carbon monoxide poisoning, one as yet unascertained and one due to asphyxiation.

There is no obvious geographical pattern across Cheshire East. Four cases were in extremely rural areas; one occurred on a farm and one appears to have done so from the postcode given. This may simply reflect the rural nature of the authority but may merit further investigation.

Three deaths in Cheshire East involved non-residents, one resident took their own life in a neighbouring local authority (Cheshire West and Chester); the remainder were all Cheshire East residents who died in Cheshire East.

In terms of occupation, two of the cases were students, six were retired, one was unemployed, one was registered disabled, one had recently been made redundant and one had recently left their job and there were two where no occupation was recorded. There was a range of other occupations, including farming. Other factors of note include relationship issues – marital breakdown in one case and argument with partner immediately prior to suicide in the other – mentioned in two cases. Another case was under police investigation. Seven cases were known to mental health services, two had had previous suicide attempts and one had a history of self-harm; three had physical health problems.

Support is offered to those immediately affected by suicide (usually the person who found the body and the next of kin) in Cheshire East through the offer of a referral to Amparo. Amparo provide one to one support in dealing with bereavement by suicide and with practical issues, such as the inquest.
Suicide is preventable yet in England 13 people take their own lives every day. The impact on family, friends, workplaces, schools and communities can be devastating; it carries a huge financial burden for the local economy and contributes to worsening inequalities. Friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss and they experience severe effects on their health, quality of life, ability to function well at work and in their personal lives. Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

Major risk factors in adults are physical health problems, mental health diagnosis, a previous suicide attempt, relationship problems, alcohol problems, drug misuse, self-harm, domestic violence and bereavement by suicide (No More Suicide – Preventing Suicide in Cheshire and Merseyside 2017). Risk factors for young people under 25 include family factors, such as mental illness, abuse and neglect, bereavement and experience of suicide, bullying, suicide-related internet use, academic pressures, social isolation or withdrawal, physical health conditions that may have social impact, alcohol and illicit drugs, mental ill-health, self-harm and suicidal ideation.

No More Suicide – Preventing Suicide in Cheshire and Merseyside 2017) identifies risk factors operating at three different levels:

**Society:** the impact of the economic recession since 2008, unemployment, welfare and benefits reform.

**Place:** Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent.

**Individual:** socio-economically deprived individuals are more exposed to suicidal risk-factors including adverse childhood experiences, chronic stress, debt, job insecurity and lack of social support.

This report calls for a focus on inequalities, men, children and young people, self-harm and safer care services. The drive for safer care services calls on primary care and mental health services to identify people at risk sooner.
Suicide and Self-harm/injury

Increasingly, a link is being identified between self-harm and completed suicide. Definitions of self-harm vary, with some studies focusing only on self-injury and others including self-poisoning and alcohol abuse.

A systematic review into fatal and non-fatal repetition of self-harm (Owens, Horrocks and House 2002) found a 0.5% incidence of suicide in people who had been hospitalised for self-harm in the previous year across all studies. Where only the better quality studies according to their criteria were included, this increased to 1.8%. The study also identified that 1 in 15 people hospitalised for self-harm took their own lives in the 9 years following admission. These results as applied to hospital admissions for self-harm in Cheshire East are tabulated below:

<table>
<thead>
<tr>
<th>Age Band</th>
<th>No of admissions* 2015/16</th>
<th>Projected suicide within 1 year (range between 1 in 200 to 1 in 40)</th>
<th>Projected suicide within 9 years (1 in 15)</th>
</tr>
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<tbody>
<tr>
<td>10-14</td>
<td>55</td>
<td>0.275</td>
<td>3.667</td>
</tr>
<tr>
<td>15-19</td>
<td>147</td>
<td>0.735</td>
<td>3.675</td>
</tr>
<tr>
<td>20-24</td>
<td>94</td>
<td>0.470</td>
<td>2.350</td>
</tr>
<tr>
<td>Total 10-24</td>
<td>296</td>
<td>1.480</td>
<td>7.400</td>
</tr>
<tr>
<td>All Ages</td>
<td>743</td>
<td>3.715</td>
<td>18.575</td>
</tr>
</tbody>
</table>

* Individuals may have had more than one admission during the time period.


This study suggests that, looked at the other way, 66% of suicides would have previously self-harmed. Applied to Cheshire East that is 14 of the 21 suicides in 2016. The paper does not discuss possible interventions in detail but stresses that any interventions should be offered to all patients presenting with self-harm. The Mental Health Return on Investment (ROI) Tool produced by Public Health England models the impact of using psychosocial interventions, principally cognitive behavioural therapy (CBT), in people who have self-harmed to prevent future self-harm episodes and suicide attempts (https://www.gov.uk/government/publications/mental-health-services-cost-effective-commissioning).

These findings are particularly applicable to young people. Zahl and Houghton (2004) followed up 11,583 patients presenting at an Oxford Hospital for self-harm (self-injury and self-poisoning) between 1978 and 1997. They found that suicide risk increased with multiple repeat episodes of deliberate self-harm and that this was especially the case in young females. Whilst they stress that suicide following self-harm is a rare event, it is still an important risk factor, particularly for the young. Source: Zahl, L.D. and Hawton, K. (2004) Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11583 patients, British Journal Of Psychiatry 185: 70-75
Suicide and Self-harm/Injury Continued

It is important to bear in mind that the prevalence of self-harm may be much greater than these studies suggest, since many cases do not present to health services. The Adult Psychiatric Morbidity Survey (APMS) estimates that 7.3% of the population have ever self-harmed (5.7% of men and 8.9% of women). The prevalence of self-harm is highest among 16-24 year olds (17.5%) but declines with age to 0.3% of those aged 75+. Applying these figures to the Cheshire East population suggests that 7,368 males and 12,174 females in Cheshire East have self-harmed at some point in their lives.

The APMS also suggests that 26,870 males and 33,641 females have had suicidal thoughts at some point in their lives and that 7,599 males and 11,886 females have attempted suicide. These figures demonstrate the extent of the issue within the general population.

If we are to eliminate suicides and reach zero we must start by preventing self-harm and suicidal behaviour in our young people and their subsequent adult lives. Prevention of suicide risk in children and young people requires schools, colleges and universities to take a holistic approach to emotional wellbeing, building resilience and positive coping skills in young people. Action to eliminate young suicides means working with our multi-agency partners to tackle adverse childhood experiences, ensure adequate mental health support, to tackle bullying/cyber-bullying and work with alcohol and drug misuse services to reduce risk.

**Strategic overview**


This strategy has the following objectives:

- A reduction in the suicide rate in the general population in England, and
- Better support for those bereaved or affected by suicide

It also identifies 6 key areas of action:

- Reducing the risk of suicide in key high-risk groups
- Tailoring approaches to improve mental health in specific groups
- Reducing access to the means of suicide
- Providing better information and support to those bereaved or affected by suicide
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
- Supporting research, data collection and monitoring

**The Cheshire and Merseyside No More-Zero Strategy**

This strategy is an all-age suicide prevention strategy, recognising that suicide and suicidal risk varies across the life course and that prevention and age-appropriate interventions are particularly important.

This 2017 update increases the focus on inequalities, men, children and young people, self-harm and safer care.

http://www.no-more.co.uk/files/no-more-strategy-2017.pdf
Crisis concordat for mental health

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Concordat focuses on four main areas:

Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.

Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.

Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

http://www.crisiscareconcordat.org.uk/about/
Assets:

Services
- Improving Access to Psychological Therapies (Central and South Cheshire) and Talking Therapies (East Cheshire)
- Survivors of Bereavement by Suicide (SOBS)
- Amparo – support for people affected by suicide
- Network Rail approach to tackling suicide
- The Samaritans

Training:
- MindEd training promoted via LSCB and Emotionally Healthy Schools
- Gatekeeper training – general and targeting vulnerable groups
- GP training
- Youth Connect 5 resilience training for parents of 10-18 years old children
- Emotionally Healthy Schools offer of training and signposting/information sharing for school staff and parents

Networks
- Local Suicide and Self Harm Reduction Group
- Engagement in CHAMPS Suicide Prevention Network

Partnerships
- Campaign World Suicide Prevention Day and Mental Health Awareness week, Time to Talk/Change etc.
- Emotionally Healthy School
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Pilot targeted intervention for men of high risk age group.

Opportunities for improvement / future developments:
- Achieve suicide safer status
- Commission large scale gatekeepers training programme
- Participate in World Suicide Prevention Day
- Ensure that any new findings about the relationship between self-harm and suicide are fed into the Emotionally Healthy Schools Self-Harm Pathway.
- Opportunities to use the Mental Health Return on Investment (ROI) Tool.
- Explore opportunities for sharing information from local A&E departments, including CQUIN coding developed by NHS East Cheshire Trust.
- Identify any gaps in service provision for people who self-harm.
- Undertake local Suicide Audit and take forward opportunities for improvement identified.
Further information:

- PHE LA Suicide prevention Planning Guidance 2016
- ChaMPs 2015 NO MORE Zero Suicide Strategy www.no-more.co.uk
- Suicide Safer Communities: https://www.livingworks.net/community/suicide-safer-communities/
- JSNA sections at www.cheshireeast.gov.uk/jsna including:
  - Drugs and alcohol
  - Childhood maltreatment (abuse and/or neglect)
  - Domestic violence
  - Children and young people’s mental health
  - Self-injury in children and young people
  - Mental health and employment
  - Lesbian, gay, bisexual, transgender+ mental health

What we don’t know but would like to know:

- Better understanding of risk factors affecting local population
- Further research on the link between self-harm and completed suicide
- Explore gaps in service provision to support people who self-harm or present with suicidal ideation
- Outcome of Gatekeeper Training programme evaluation.
- Effective interventions for males aged 45-64

Version control

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<tr>
<th>Publication date</th>
<th>Changes made</th>
<th>Sign-off</th>
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<tr>
<td>June 2018</td>
<td>New JSNA section created to replace 2012 suicide JSNA</td>
<td>Fiona Reynolds (Public Health)</td>
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<tr>
<td>July 2018</td>
<td>Correction to estimated prevalence figures on page 8</td>
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Suicide Prevention JSNA (page 12 of 12)