Statistical update on suicide

September 2012

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Statistical update on suicide

September 2012

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Introduction

1. This update has been prepared to draw together key statistics and information relevant to *Preventing suicide in England: A cross-government outcomes strategy to save lives*.

2. Most deaths are certified by a medical practitioner; however, suspected suicides must be certified after a coroner's inquest. A coroner records a verdict of suicide when they have decided that there is evidence beyond reasonable doubt that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts include cases where the evidence available to coroners is not sufficient to conclude that the death was a suicide (beyond reasonable doubt) or an accident (on balance of probability). They include those where there may be doubt about the deceased's intentions.

3. Statistics on causes of death produced by the Office for National Statistics (ONS) are based on the information provided at death registration. These statistics are provided to the Department of Health on an annual basis. Open verdicts are generally coded by the ONS as deaths from injury or poisoning of undetermined intent. When national statistics are presented, suicides and deaths of undetermined intent are combined. This reflects research studies which show that the majority of open verdicts are most likely suicides, although they do not meet the high legal standard of evidence required for a coroner to record a suicide verdict. Therefore official suicide rates are measured by a definition that is much broader than the definition of suicide used by coroners.

4. In the remainder of this update we use the term suicide to refer to deaths from both intentional self-harm and injury or poisoning of undetermined intent.

Suicide numbers and rates

5. The number of suicide deaths refers to the actual number of people who have taken their own life.

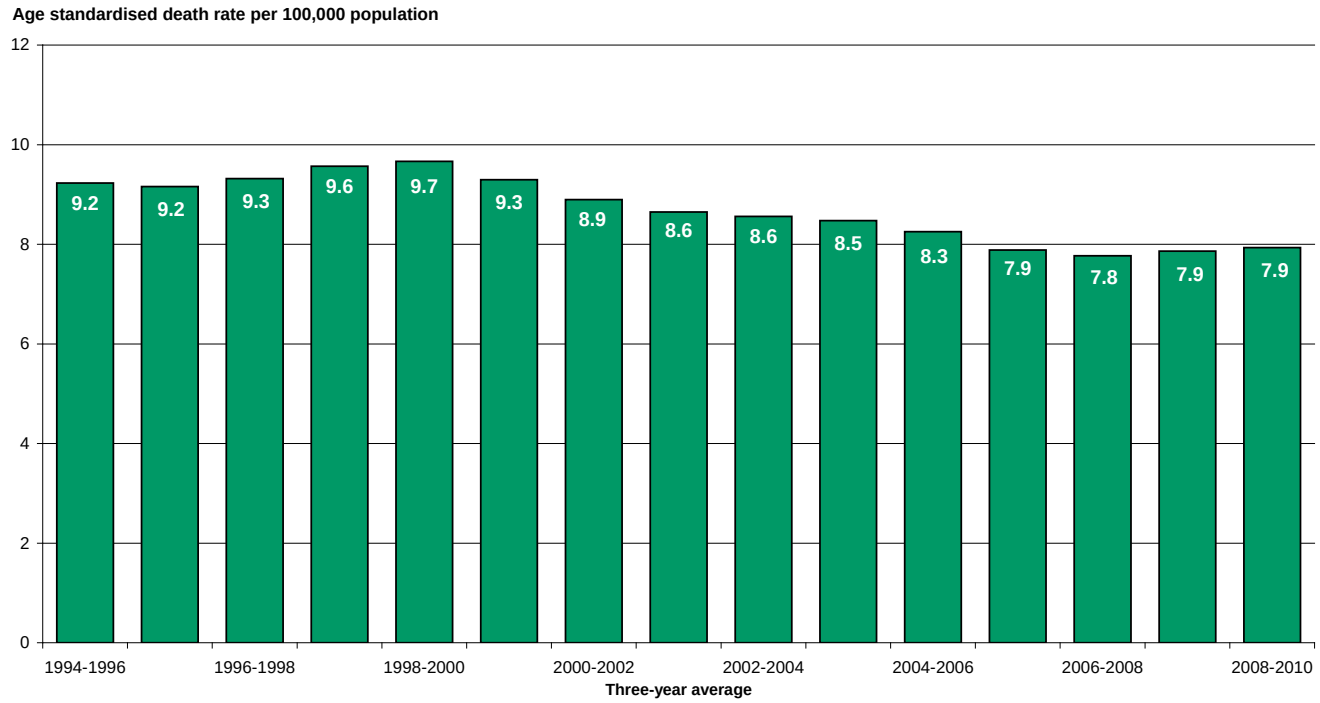
6. The rate of suicide refers to the frequency with which suicide occurs relative to the number of people in a defined population. The published rates are age-standardised to take account of changes in the size and age structure of the population to provide a comparable trend across time and across different areas.

7. Three-year rolling averages are generally used for monitoring purposes, in preference to single-year rates, in order to produce a smoothed trend from the data and to avoid drawing undue attention to year-on-year fluctuations instead of the underlying trend.

Current position

8. There were 4,215 suicides recorded in 2010. Over the past decade, the general trend has been a decrease in the overall rate of suicides. The three-year average rate for 2008-10 was 7.9 suicides per 100,000 general population, 17.9% lower than in 1998-2000. However, the most substantial decreases were seen towards the beginning of this period and data show a very slight increase in deaths from suicide in more recent years.

Figure A.1: Death rates from Intentional Self-harm and Injury of Undetermined Intent, England 1994-2010

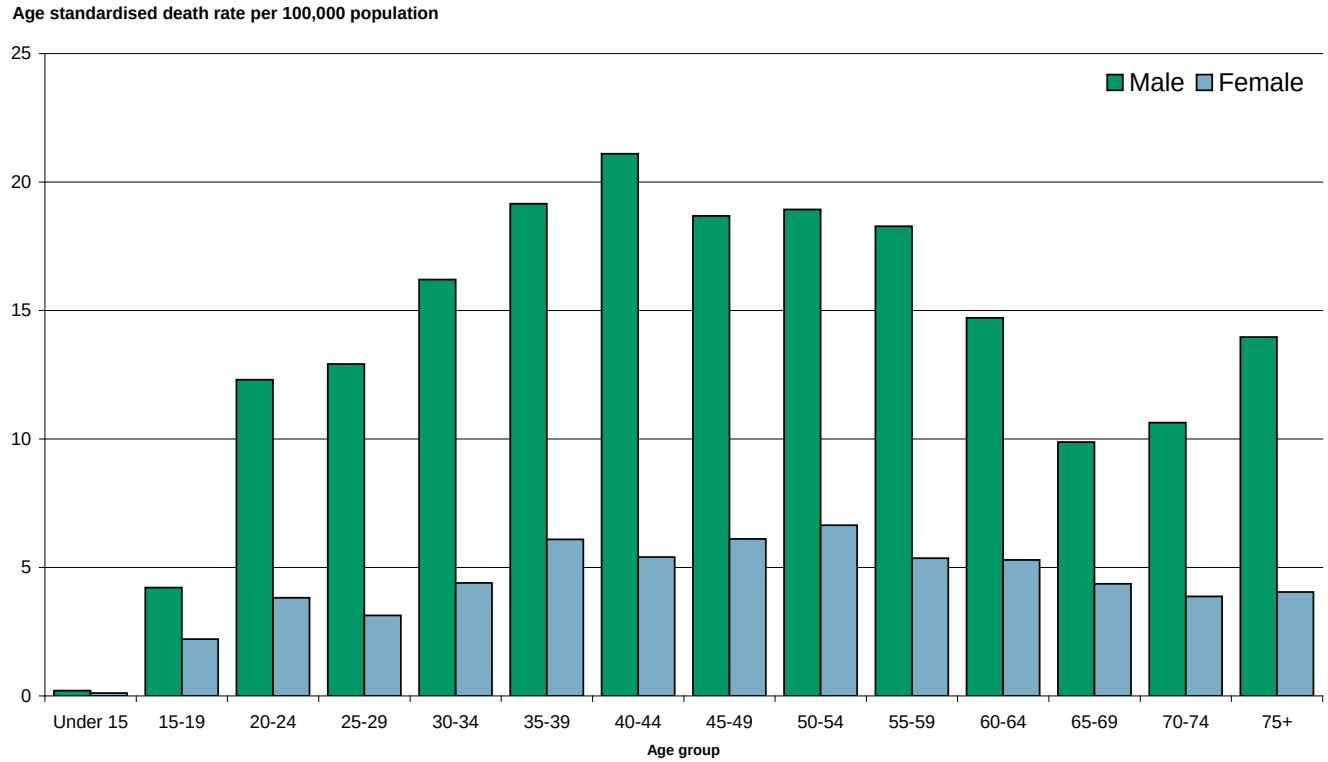


Source: ONS (ICD9 E950-E959, E980-E989, excluding E988.8; and ICD10 X60-X84, Y10-Y34, excluding Y33.9 up to 2006)
Note: Deaths with a E988.8 or Y33.9 code were excluded to remove pending verdicts from the figures. This method may miss a small number of cases where there are pending verdicts (assigned to codes other than E988.8 or Y33.9); it may also wrongly omit some cases where a verdict has been returned (included under codes E988.8 or Y33.9). We expect the error caused by this methodology to be negligible for figures in years up to and including 2006 and there will be no effect on more recent figures due to new codes introduced in 2007.

9. The majority of suicides continue to occur in adult males. In comparison to women of the same age, men are more likely to take their own lives, but the difference varies by age. Latest figures show the peak difference, both in terms of number of suicides and rate, is in the 25-29 age group, where there are more than four male suicides for each female suicide.

10. The difference between male and female suicide rates is also noticeable in those aged 75+. Although a comparably low number of suicides occur for both males and females in this group, the low population makes the rate per 100,000 population relatively large, particularly for men.

Figure A.2: Death rates from Intentional Self-harm and Injury of Undetermined Intent by five-year age band and sex, England 2010

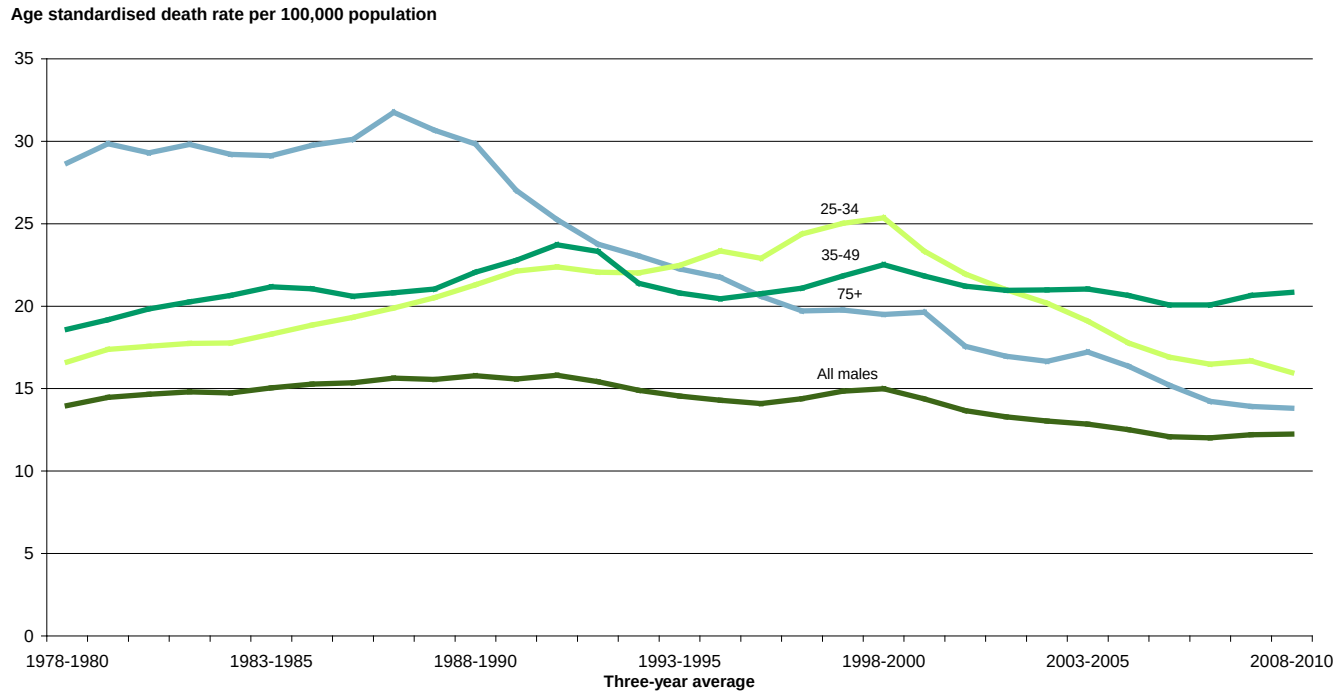


Source: ONS (ICD10 X60-X84, Y10-Y34)

11. In the years preceding the publication of the last suicide strategy in 2002, there was a large increase in the suicide rate among young males (figure A.3). Although remaining high in comparison to the general population, the suicide rate for young men has since fallen. Likewise, the suicide rate for males in the 75+ age group has continued to decline in recent years.

12. The group with the highest suicide rate is now middle aged men, where we have seen a slight increase in recent years. In 2008-10 the three-year average rate for 35-49 year old males was 20.8 per 100,000 population.

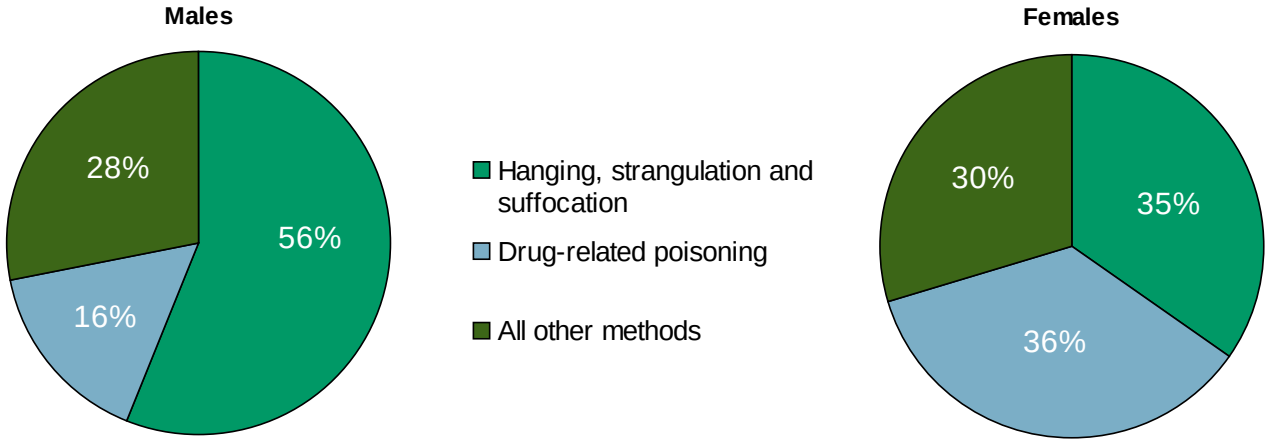
Figure A.3: Trend in deaths from Intentional Self-harm and Injury of Undetermined Intent for males (by selected age group), England (1978-2010)



Source: ONS (ICD9 E950-E959, E980-E989, excluding E988.8; and ICD10 X60-X84, Y10-Y34, excluding Y33.9 up to 2006)
Note: Deaths with a E988.8 or Y33.9 code were excluded to remove pending verdicts from the figures. This method may miss a small number of cases where there are pending verdicts (assigned to codes other than E988.8 or Y33.9); it may also wrongly omit some cases where a verdict has been returned (included under codes E988.8 or Y33.9). We expect the error caused by this methodology to be negligible for figures in years up to and including 2006 and there will be no effect on more recent figures due to new codes introduced in 2007.

13. Provisional data for 2011 suggest hanging, strangling and suffocation continue to be the most common methods of suicide for men, accounting for more than half of all male suicide deaths. Along with drug-related poisoning, this is also a common method amongst women, with each accounting for just over a third of all female suicides in 2011.

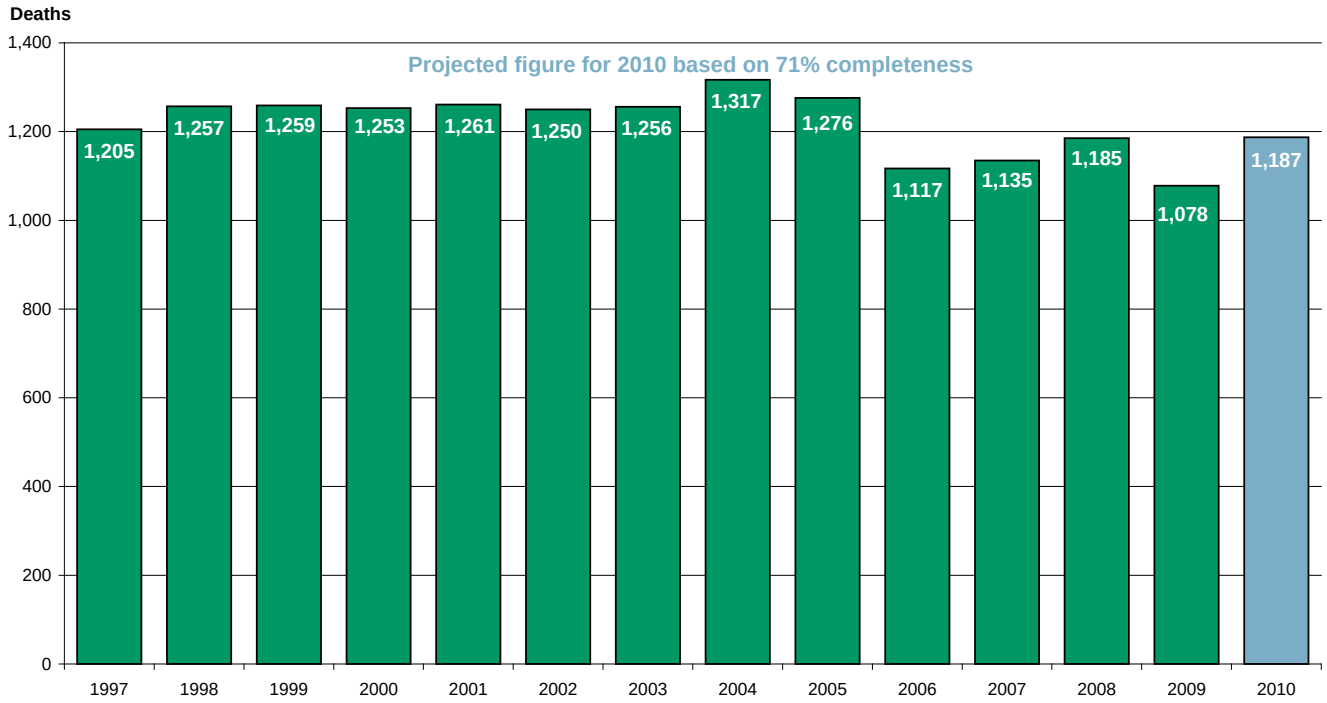
Figure A.4 Deaths from Intentional Self-harm and Injury of Undetermined Intent by method and sex, England 2011 (provisional)



Source: ONS (ICD10 X60-X84, Y10-Y34)

14. In 2009 there were 1,078 suicides by people in contact with mental health services in the year prior to death (Figure A.5). The projected figure for 2010 is 1,187 and is calculated from the proportion of questionnaires that have been returned to the National Confidential Inquiry into Suicide and Homicide by people with mental Illness. This projection is based on 71% of questionnaire returns and may change as data for cases identified in 2010 become more complete.

Figure A.5: Suicides by people in contact with mental health services (in 12 months prior to death), England 1997-2010*

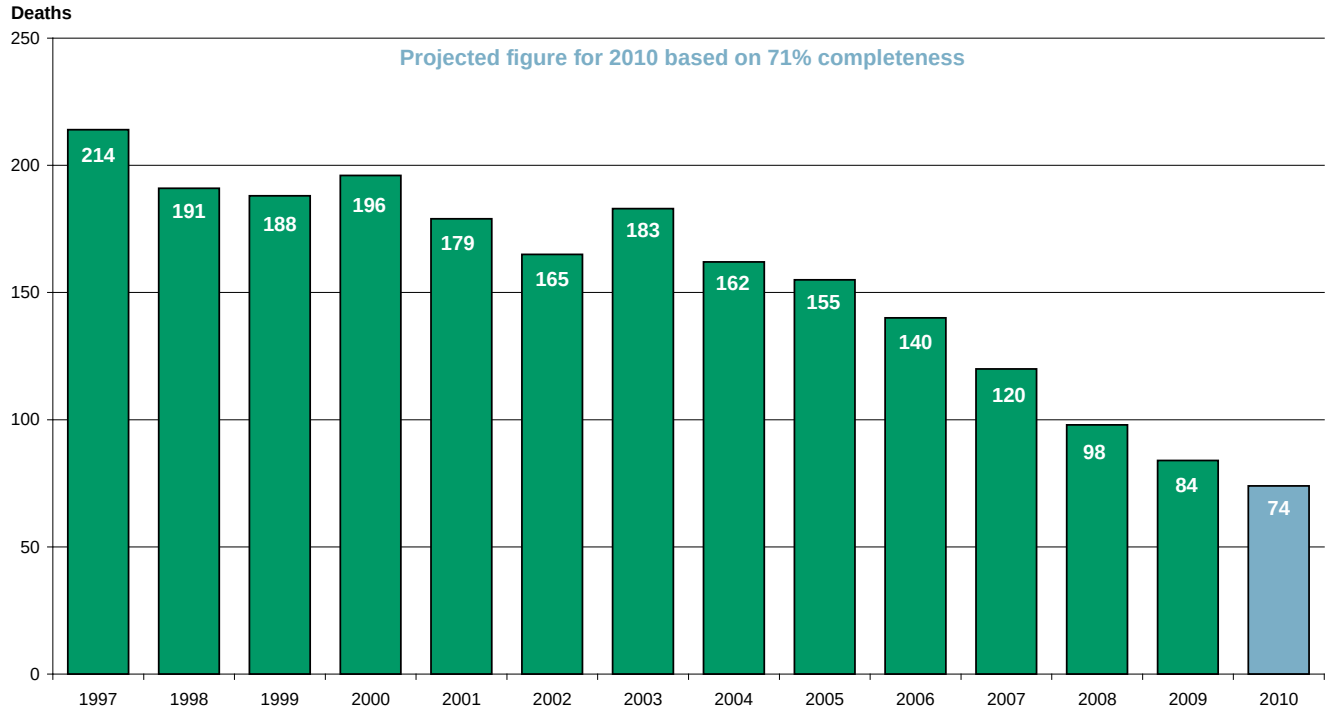


*The projected figure for 2010 provides the most accurate estimate of the number of cases expected. The projected figure may change as data becomes more complete.

Source: National confidential Inquiry into Suicide and Homicide by people with mental illness

15. The latest data show the number of inpatients taking their own life in England has continued to fall, with 84 inpatient suicides in 2009 (Figure A.6). The projected figure for 2010 shows 74 inpatient suicides.

Figure A.6: Inpatient suicides, England 1997-2010*

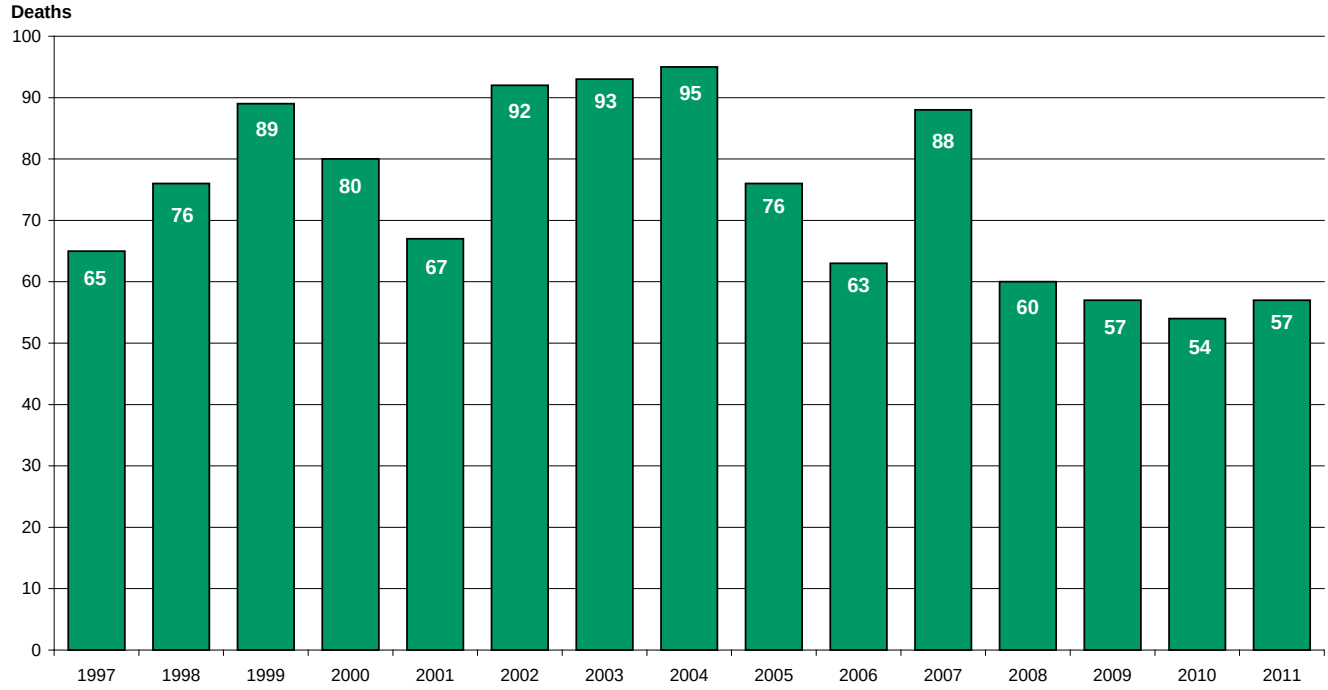


*The projected figure for 2010 provides the most accurate estimate of the number of cases expected. The projected figure may change as data becomes more complete.

Source: National confidential Inquiry into Suicide and Homicide by people with mental illness

16. Figure A.7 shows the number of self-inflicted deaths in prisons between 1997 and 2011.

Figure A.7: Self-inflicted deaths* in prison, England 1997-2011



*Prisoner 'self-inflicted deaths' include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80 percent of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

Source: National Offender Management Service

Other sources

17. Existing research evidence and other relevant sources of data which are useful to inform local and regional strategies and interventions to prevent suicide include:

- ONS currently produces national mortality statistics from the information supplied to the registrar on cause of death. This information includes age, sex and occupation of the deceased, their usual place of residence, the method of suicide used and the location of their death. These statistical data are used nationally and locally to identify priorities for health care and public policy, to measure progress, and to assess the effectiveness of health services and other interventions.

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) – this is a long-term study of suicides and homicides by people in the care of the mental health services. Conducted by the Centre for Mental Health and Risk at the University of Manchester, it has published a number of reports on incidence, trends, causes and recommendations for improving suicide prevention. Services adopting these recommendations have been found to have lower patient suicide rates (see http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci/).

- The Multicentre Study of Self-harm in England – this project is collecting data on national and regional trends in self-harm presenting to health services, including data on methods of self-harm, how self-harm is managed, compliance with national guidance, and self-harm in young people and in different ethnic groups. The study is also able to collect important data on outcomes (including suicide), and risk factors.

- Coroners' records from inquest proceedings can provide a wealth of information about the who, how and where of suicides, which tell us about the demographics of suicide, and may also tell us more about the motivations and causes of suicide.

- Important additional information is available from serious untoward incident inquiries, Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The purpose of SCRs and CDOPs are to learn lessons to better safeguard and promote the welfare of children. Regular reports draw out key findings from SCRs. The Department for Education publishes data about preventable child deaths in England.

- The National Offender Management Service (NOMS) has a system in place to monitor all deaths and other incidents in prison custody. This provides up to date information on each incident and those involved. Since 2009, the Ministry of Justice has published an annual statistical bulletin on deaths, self-harm and violence in prison custody, looking at trends across age, gender and time in prison custody. In addition, the Prisons and Probation Ombudsman publishes a report on every fatal incident in prison custody.