WOKINGHAM BOROUGH COUNCIL

CHAPTER 4: SUICIDE AND SELF-HARM

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4 SUICIDE AND SELF-HARM

4.1 Introduction

Suicide is a devastating event which, aside from resulting in tragic loss of life, has a ripple effect on others. Suicide is *"the act of intentionally taking your own life"* (Mind, 2020). It is the fourth leading cause of death globally in 15–29-year-olds. Factors which contribute to a person's decision to take their own life are complex and, in many cases, there is usually no single cause. There are established links between suicide and mental health conditions such as depression, and alcohol use disorders. There are also other factors which are strongly associated with suicidal behaviour. There are a large number of people who attempt suicide each year, and a prior attempt is one of the most important signs and risk (WHO, 2021).

Self-harm is defined as "*any act of self-poisoning or self-injury carried out by an individual irrespective of motivation*" (National Institute for Health and Care Excellence, 2013). Although self-harm is not necessarily a suicide attempt, it remains a prominent risk factor for suicide later in life. Each individual will have different contributing circumstances to why they self-harmed and they will have different episodes of self-harm but there is complex relationship between suicide and self-harm which needs to be further understood (Samaritans, 2020).

This chapter provides an overview of suicide and self-harm prevalence among adults aged 18 years or older in Wokingham and England and, where available, looks at data related to risk factors.

4.2 Suicide risk factors

Suicide is a complex issue, often it is the interplay between several different underlying factors and, is very different in every case. Despite this there are several factors which are often present in the cases of those who commit suicide (Box 4:1).

There are also groups with greater risk of suicide than others, that is they are at higher risk of having one or more multiple indicators of risk for suicide e.g., self-harm, rather than 'belonging' to the group being a risk factor in itself. These groups are:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people in contact with the criminal justice system
- children and young people
- young and new mothers
- LGBTQ+, being LGBTQ+
- There are also some occupations linked to having a significantly higher risk of suicide. These include those who work as carers, in the arts, low-skilled workers, men who are skilled manual workers, female nurses, nursery or primary school teachers (Public Health England., 2019) (National Institute for Health Research, 2021) (Office for National Statistics , 2017).

Box 4:1: Risk factors associated with suicide (Centers for Disease Control and Prevention, 2021) (Mental Health Foundation , 2021)

- Previous suicide attempts, or previous self-harm
- Financial problems and being unemployed
- Having a physical health problem, including chronic pain
- Social isolation/living alone
- Being dependent on alcohol or drugs
- Having mental health problems
- Criminal problems
- Impulsive or aggressive tendencies
- Legal problems
- Adverse childhood experiences such as child abuse and neglect
- Bullying
- Family history of suicide
- Relationship problems such as a break-up, violence, or loss
- Sexual violence
- Barriers to health care
- Cultural and religious beliefs such as a belief that suicide is noble resolution of a personal problem
- Easy access to lethal means among people at risk (e.g., firearms, medications)
- Unsafe media portrayals of suicide

4.3 Self-harm risk factors

There is strong association in those who have self-harmed being at greater risk of suicide compared to those who do not self-harm (Chan, et al., 2016) (Cooper, et al., 2005). Evidence shows that an estimated 50% of people who have died by suicide have previously self-harmed and there are approximately 200,000 hospital attendances for self-harm each year (UK Government , 2021).

The risk factors for self-harm include (National Institute for Health and Care Excellence, 2020):

- Age: self-harm rates peak in 16 to 24-year-old women and 25 to 34-year-old men. Suicide rates are highest in both men and women aged 45–49 years.
- Socio-economic disadvantage.
- Social isolation.
- Stressful life events, for example, relationship difficulties, previous experience in the armed forces, child maltreatment, or domestic violence.
- Bereavement by suicide.
- Mental health problems, such as depression, psychosis or schizophrenia, bipolar disorder, post-traumatic stress disorder, or a personality disorder.
- Chronic physical health problems.
- Alcohol and/or drug misuse.
- Involvement with the criminal justice system (with people in prison being at particular risk).

There are some groups which have higher incidence of self-harm including individuals who identify as LGBTQ+, young people, particularly children who are care leavers and looked after children. Rates of self-harm have been increasing since

2000 especially in young people. A national survey has shown girls reporting previously self-harming three times higher than boys (Public Health England., 2019).

4.4 Prevalence of some of the suicide and self-harm risk factors

4.4.1 Adverse childhood experiences

The risk of suicide attempts is two to four times greater in adults who had suffered childhood abuse or other adverse childhood experiences (e.g., physical neglect). The risks associated with some of the specific adverse childhood experiences are (Zatti, et al., 2017):

- Sexual abuse (odds ratio: 4, 95% CI 3-5)
- Physical abuse (odds ratio: 4, 95% CI 2-7)
- Emotional abuse (odds ratio: 4, 95% CI 3-6)
- Physical neglect (odds ratio: 3, 95% CI 2-6)

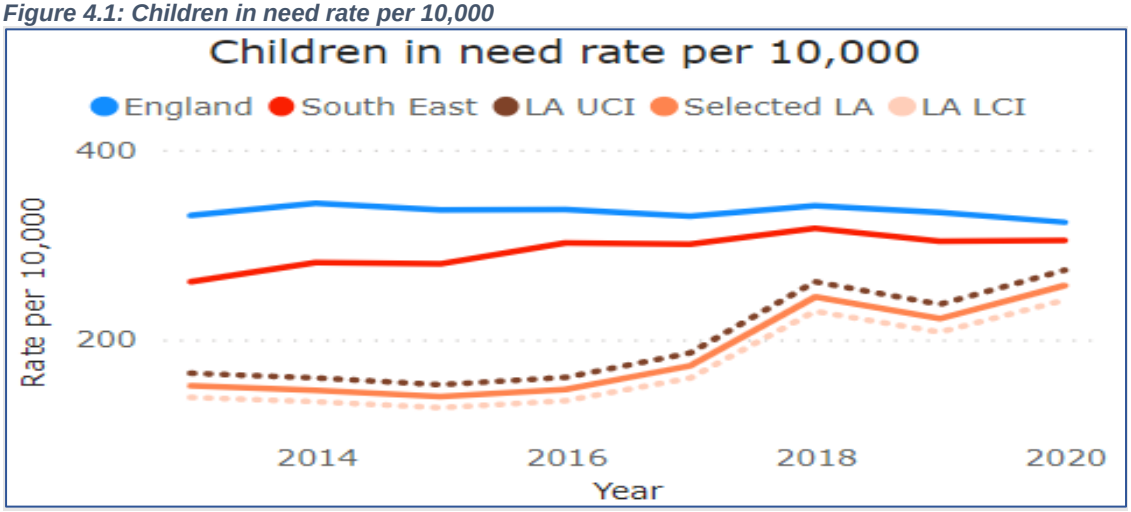
4.4.1.1 Children in need

'Child in Need' is a broad definition spanning a wide range of children and adolescents, in need of varying types of support and intervention, for a variety of reasons. A child is defined as 'in need' under section 17 of the Children Act 1989, where:

- they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for them of services by a local authority
- their health or development is likely to be significantly impaired, or further impaired, without the provision for them of such services; or
- they are disabled

Figure 4.1 shows the number of children who are defined as "*in need*" as of 31st March 2020 as a rate per 10,000 children aged 0-17. This follows a similar increasing trend over the same period, showing the number of children subsequently assessed as being "in need" increased from 172 referrals per 10,000 in 2017 to 257 referrals per 10,000 in 2020.

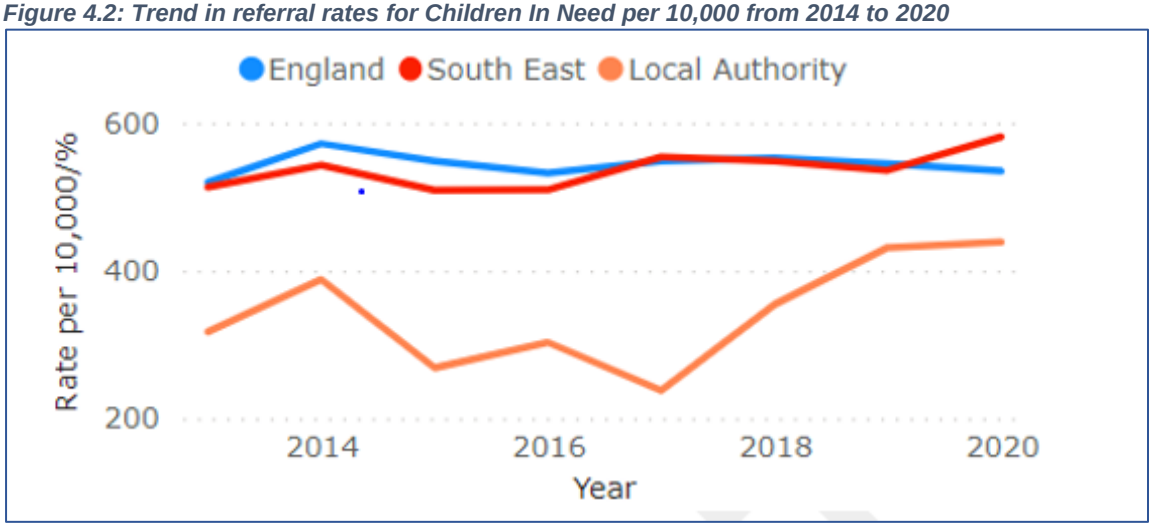
Figure 4.1: Children in need rate per 10,000



Source: (Department for Education , 2022)

Figure 4.2 shows children in need referrals trends in England, South East, and Wokingham (Local Authority). Referral rate is shown as a rate per 10,000 children aged 0-17. An increase in referral can be seen from just over 200 per 10,000 in 2017 to over 400 per 10,000 in 2019 and 2020, in Wokingham.

Figure 4.2: Trend in referral rates for Children In Need per 10,000 from 2014 to 2020



Source: (Department for Education, Characteristics of Children in Need, reporting year 2020)

Table 4.1 shows the number and percentage of children in need in Wokingham on the 31st of March 2020. Data captures primary factor identified at the time of the initial assessment, with domestic violence and the mental health of a parent being the top two factors identified. It should be noted that this data was a 'snapshot 'a captured one 24hr period only and so should be used in caution as it may not give a true reflection of the overall picture locally, with rates potentially being higher and reported factors differing.

Table 4.1: Factors identified at the end of assessment

Factor identified at the end of assessment (selected LA)

Year	2018		2019		2020		Total	
Factor identified	Count	%	Count	%	Count	%	Count	%
Domestic Violence parent	299	32%	534	35%	437	30%	**1270**	**32%**
Mental Health parent	220	24%	390	25%	360	25%	**970**	**25%**
Emotional Abuse	169	18%	320	21%	301	21%	**790**	**20%**
Neglect	134	14%	362	24%	239	16%	**735**	**19%**
Domestic Violence child	161	17%	304	20%	213	15%	**678**	**17%**
Alcohol Misuse parent	144	15%	226	15%	195	13%	**565**	**14%**
Learning Disability child	175	19%	130	8%	225	16%	**530**	**14%**
Physical Abuse	116	12%	227	15%	180	12%	**523**	**13%**
Drug Misuse parent	113	12%	170	11%	144	10%	**427**	**11%**
Socially unacceptable behaviour	79	8%	160	10%	158	11%	**397**	**10%**
Mental Health child	71	8%	156	10%	156	11%	**383**	**10%**

Source: (Department for Education , 2022)

4.4.1.2 Looked after children

A child is looked after by the local authority if a court has granted a care order to place a child in care or a council's children's services department has cared for the

child for more than 24 hours. Within Wokingham, children starting to be looked after, being looked after or ceased being looked after are lower than for England and the South East.

Table 4.2 shows a decrease in those starting to be looked after accompanied by an increase in those ceasing to be looked after, which has resulted in a slight decrease in looked after children's rates in Wokingham over the past 3 years. (Rates shown as per 10,000 children aged under 18 years)

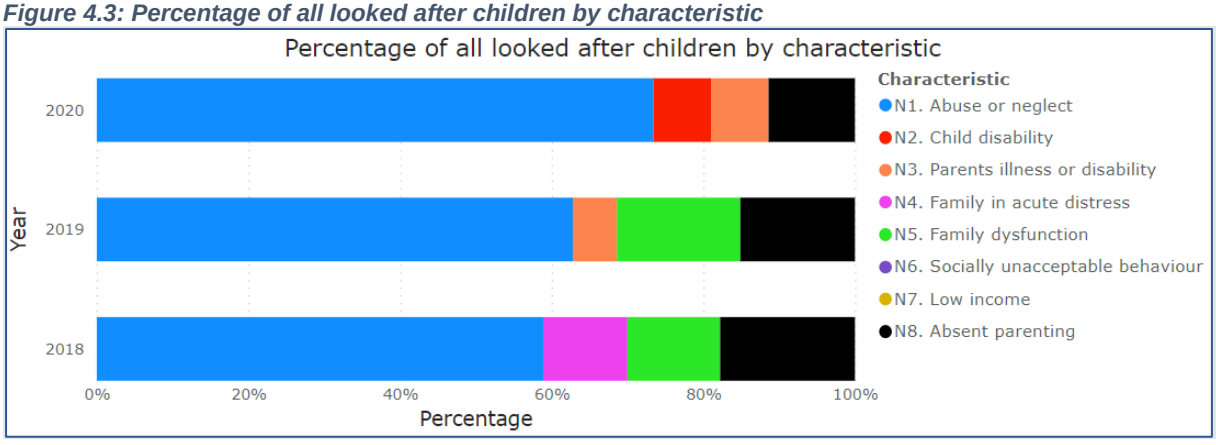
Table 4.2: Rate of Looked after children England, Southeast and Local Authority (Wokingham) rate per 10,000 children aged under 18 years, 2018 - 2020

Category	England	South East	Local Authority	LA Count	Diff. against England	Diff. against South East
Children starting to be looked after each year						
2020	25.7	22.2	10.9	44	Low	Low
2019	26.6	22.3	15.7	62	Low	Low
2018	27.1	22.5	17.1	66	Low	Low
Children looked after at 31 March each year						
2020	65.7	53.1	24.2	98	Low	Low
2019	64.5	52.5	27.8	110	Low	Low
2018	62.8	51.4	27.4	106	Low	Low
Children ceasing to be looked after each year						
2020	24.7	21.6	13.6	55	Low	Low
2019	24.9	21.3	14.7	58	Low	Low
2018	25.4	22.2	9.3	36	Low	Low

Source: (Department for Education , 2022)

Figure 4.3 shows the percentage of all looked after children by 'characteristic'. Nearly 70% of children are looked after due to a primary need of abuse or neglect, this has increase year-on-year since 2018. Wokingham was found to have significantly higher rates than regional averages for children in need due to parents' disability or illness. It should be noted that these differences may be due to a higher identification rate of children in need rather than been a true difference.

Figure 4.3: Percentage of all looked after children by characteristic



Source: (Department for Education , 2022)

4.4.2 Homelessness

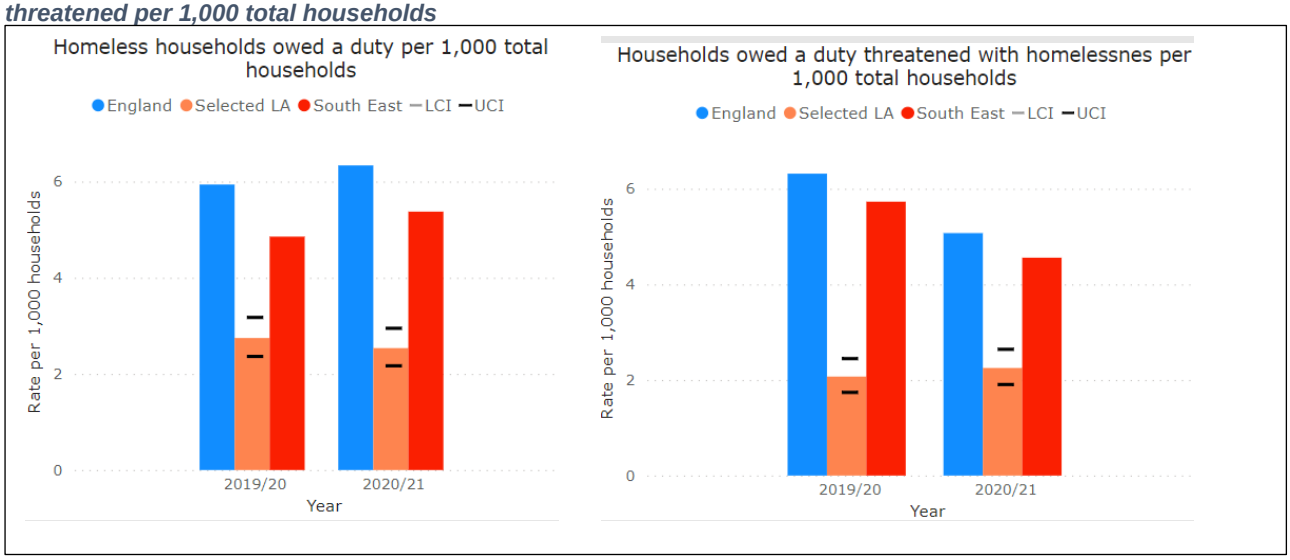
Suicide is the third most common cause of death amongst people who are homeless in England with 10.8% of deaths amongst homeless people or rough sleepers being

due to suicide in 2020 (Office for National Statistics, 2021). Homeless people are over 9 times more likely to commit suicide than the general population and have higher prevalence of mental health problems (Crisis, 2011).

Evidence shows that homeless people who have died by suicide, usually have had more risk factors contributing to suicide than those in stable accommodation and are more likely to be young, male, unemployed and unmarried. They also usually have experienced a stressful life event prior to their deaths, as frequently there is physical illness and a drug and alcohol problems (Culatto , Bojanic, Appleby, & Turnbull, 2021).

Figure 4.4 shows the number of Wokingham households who are owed a duty by the local authority. Data is shown for those who are homeless (relief duty owed) and those threatened with homelessness with 56 days (prevention duty owed). The charts show Wokingham rates are statistically significantly lower than England and the South East averages.

Figure 4.4: Homeless households owed a duty per 1,000 total households/ Households owed a duty threatened per 1,000 total households



Source: Ministry for Housing, Community and Local Government Live Homeslessness Tables

4.4.3 Common or severe mental health conditions

Common or severe mental health conditions are strong predictors for suicides, particularly for those people under mental health care. Research shows that disorders such as, depression, alcohol use and psychosis are associated with an increased risk of suicide (Windfuhr & Kapur, 2011). It is estimated that there is a 10-fold increase of suicide risk for people under mental health care for mental health conditions and in England there are approximately 1200 to 1300 patient suicides each year.

The data on local prevalence and estimated prevalence of severe enduring mental illness and common mental health disorders can be found in the respective chapters of this needs assessment.

4.4.4 Alcohol and drug use

People with mental health co-existing with drug/alcohol use conditions are more likely to self-harm or die by suicide. In 2017, 57% of people who died by suicide had a history of drug or alcohol misuse (National Institute for Health Research, 2021).

The risk of drug and/or alcohol misuse are highest amongst people experiencing multiple or severe disadvantages. An example of this is particularly prominent in homeless people, where in 2017 over of half of deaths were due to alcohol, drugs or suicide (Public Health England., 2019). Substance misuse is also known to be a common risk factor for suicide in other high-risk groups such as middle-aged men, who have the highest rates of suicide, and young people, in whom rates are increasing (National Institute for Health Research, 2021).

Local data specifically about alcohol and drug use in Wokingham can be found in the Substance Use chapter.

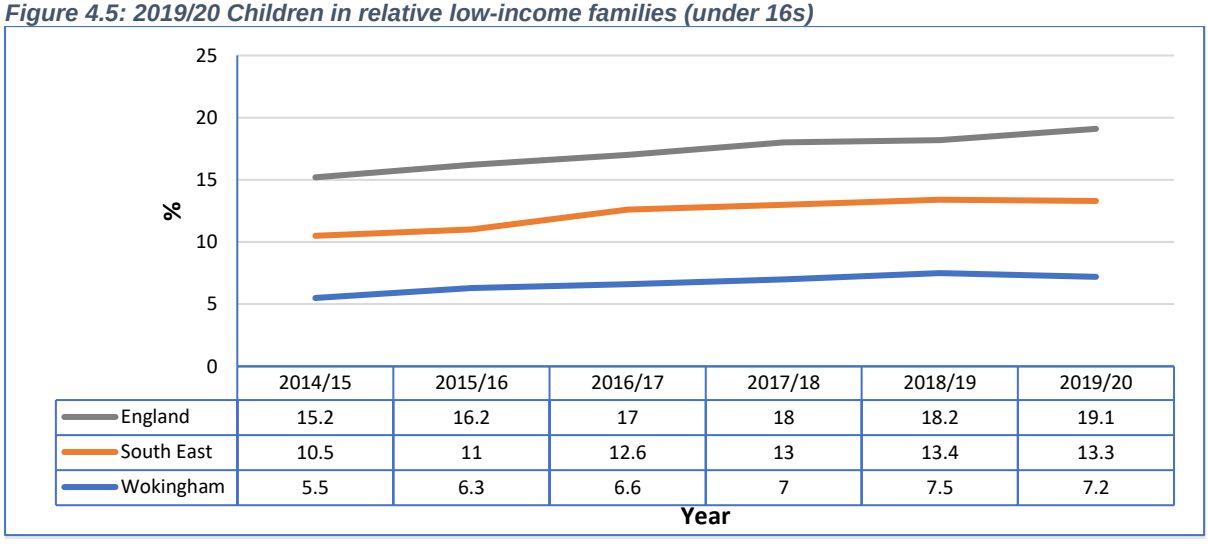
4.4.5 Economic factors:

4.4.5.1 Relative low-income families

Relative low income is defined as a family in low income before Housing Costs (BHC) in the reference year. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics.

Figure 4.5 indicates that Wokingham has the lowest rate of children living in low-income families within the Southeast region. In 2019/20 7.2% of children lived in relative low-income families, in comparison to 13.3% in the Southeast and 19.1% in England.

Figure 4.5: 2019/20 Children in relative low-income families (under 16s)



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
England	15.2	16.2	17	18	18.2	19.1
South East	10.5	11	12.6	13	13.4	13.3
Wokingham	5.5	6.3	6.6	7	7.5	7.2

Source: (Department for Work and Pensions/HM Revenue and Customs)

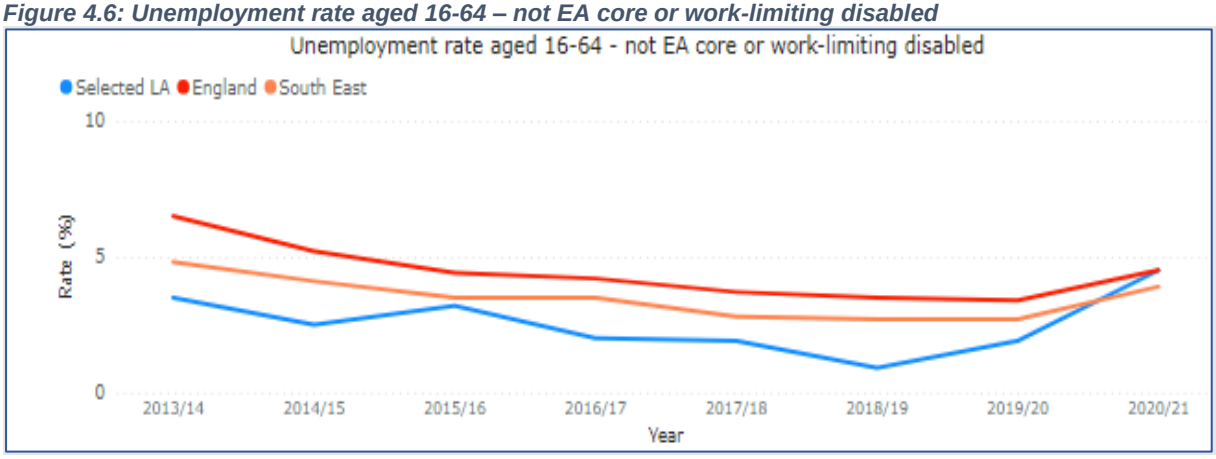
4.4.5.2 Unemployment

Economic factors, particularly unemployment have been shown as strong risk factors of suicide. Locally, data from the 2014/15 to 2017/18 Berkshire Suicide Audit showed that between 2007 and 2018, the percentage of suicides that were amongst people

who were unemployed ranged from 11% to 38%. If we consider this against the fact that 4% of the overall population in Berkshire are unemployed, then people who are unemployed are over-represented in the number of suicides in Berkshire.

The term “economically active” refers to all people aged 16 to 64 at a specified time. Data from 2020/21 (Figure 4.6) indicates that locally in Wokingham the unemployed percentages of those economically active were similar to the national and South East averages in 2020/21 with Wokingham recording an unemployment rate of 4.5%.

Figure 4.6: Unemployment rate aged 16-64 – not EA core or work-limiting disabled



Source: (Office of National Statistics , 2022)

4.5 Protective factors

Protective factors increase an individual’s ability to survive against suicidal behaviour, promote resilience and can reduce the likelihood of suicide (McLean, Maxwell, Platt, Harris, & Jepson, 2008) (Holman & Williams, 2020). There is less research available surrounding protective factors for suicide as there is more of a focus on risk factors. Protective factors can differ between individuals and change over time.

Evidence shows that there are some common protective factors against suicide (Holman & Williams, 2020) (Sinclair & Leach, 2017):

- Family support/ social support
- A strong religious faith
- Problem solving skills
- A sense of responsibility for others
- Having children at home
- Self-esteem
- Sense of belonging
- Stable employment
- Resilience
- Access to mental health services as well as a positive attitude towards them

4.5.1 COVID-19

At the time of writing this section, emerging evidence did not show a significant rise in suicide in UK during the COVID lockdown (Appleby, et al., 2021) and pattern is

similar in other high income countries (John, Pirkis, Gunnell, Appleby, & Morrissey, 2020).

For more information on Covid-19 and suicide please see the relevant chapter in this needs assessment.

4.6 Suicide and self-harm prevalence

4.6.1 National profile

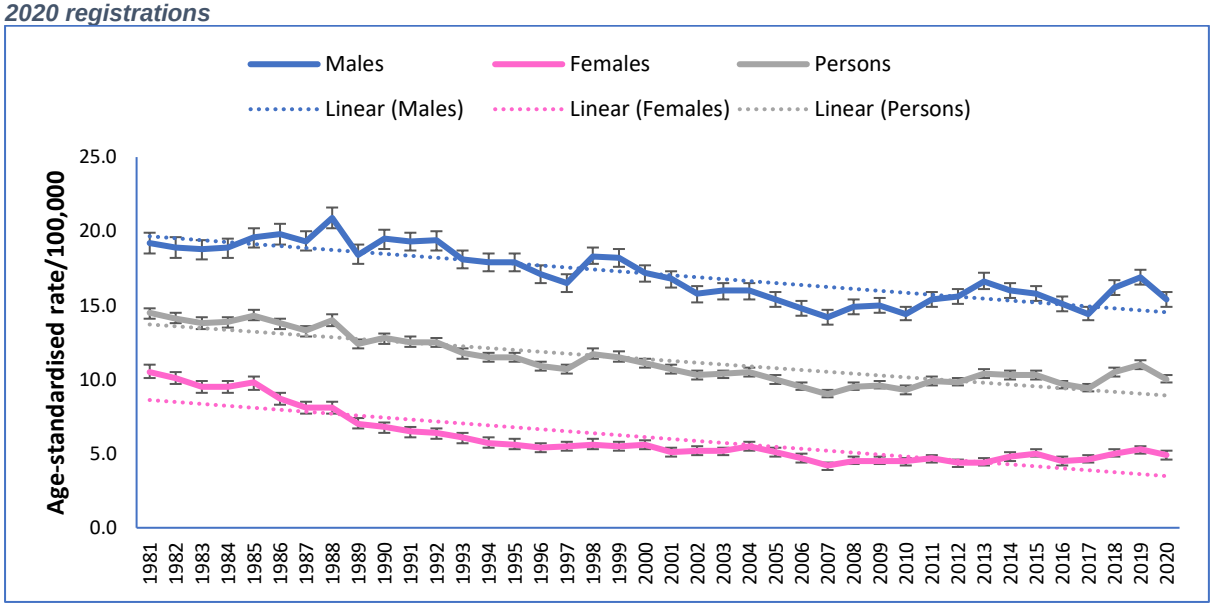
Suicide is the leading cause of death in males under 50 in England. In England and Wales, in 2020 there were 5,224 suicides registered. Roughly three quarters of these suicides were men, with those in the age range of 45-49 years having the highest suicide rate for both men and women (Office for National Statistics , 2020).

According to the 2014 Adult Psychiatric Morbidity Survey (NHS Digital, 2016), the proportion of people aged 16–74 years who reported having ever self-harmed increased from 2.4% in 2000, to 3.8% 2007, to 6.4% in 2014. This increase was observed in both men and women and across age groups. 25.7% of 16 to 24-year-old women reported having self-harmed at some point which was more than twice the rate for men in this age group (9.7%). The rate in women aged 25–34 years was 13.2%.

4.6.1.1 National trends – Suicide

Suicide rates in England and Wales has declined since 1981 among both sexes (Figure 4.7). However, the rate among males has remained significantly above the population average and in 2020 it was 3.1 times higher than that for females compared with 1.8 in 1981, indicating a significant widening in the gap between males and females.

Figure 4.7: Age-standardised suicide rates per 100,000 population by sex, England and Wales, 1981 to 2020 registrations

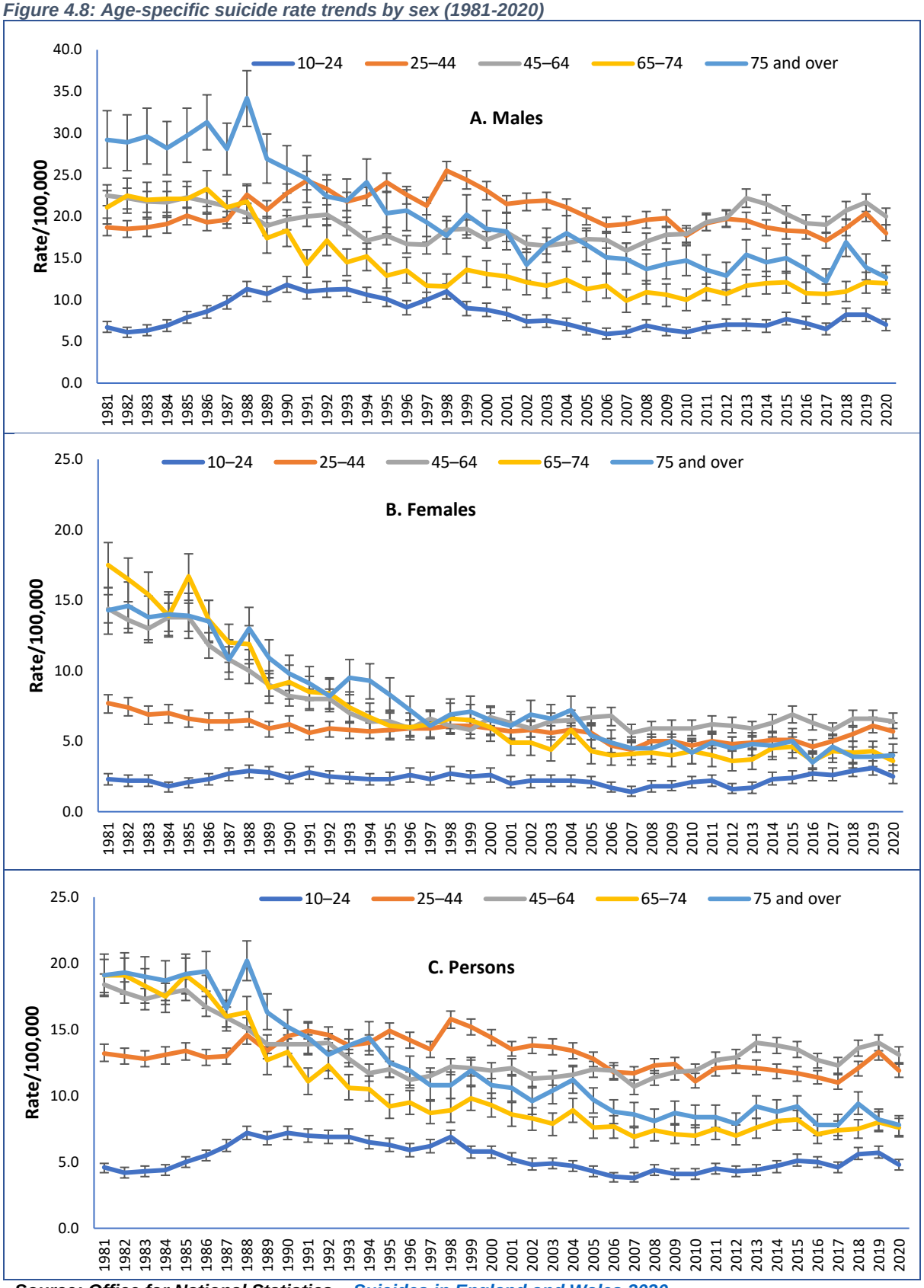


Source: Office for National Statistics – Suicides in England and Wales 2020

Overall, the biggest decline was in those aged 75 years or older, but among females the biggest decline was among those aged 65-74 years (Figure 4.8). The rate mong

10-24-year-olds has increased from the lows of the early 1980's (4.2 – 4.6 per 100,000) to 4.2/100,000 in 2020 (Figure 4.8: C).

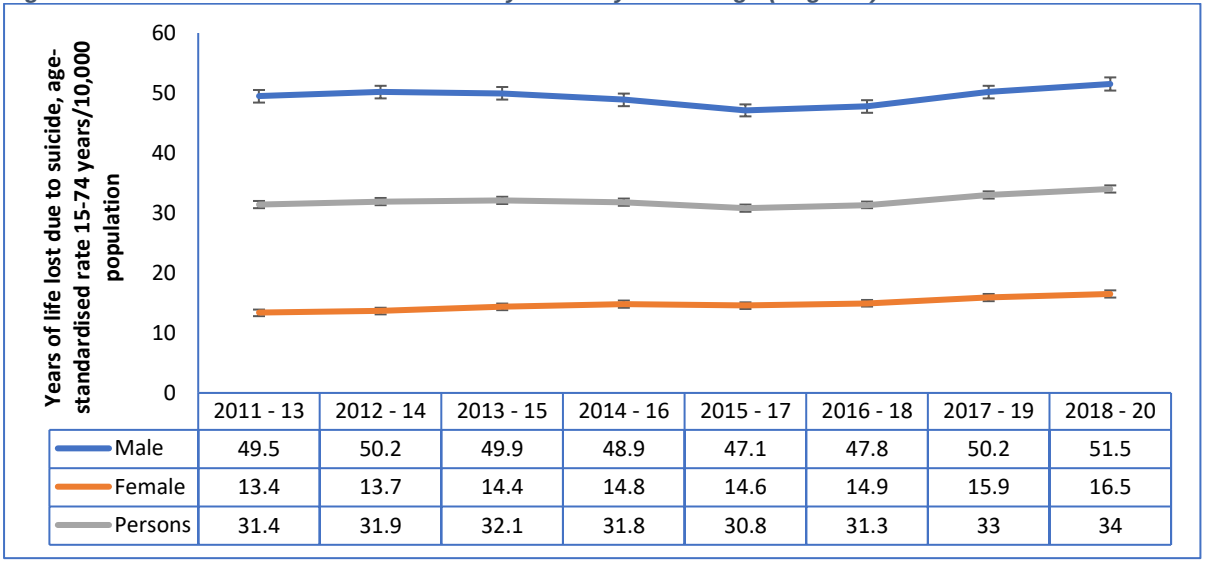
Figure 4.8: Age-specific suicide rate trends by sex (1981-2020)



Source: Office for National Statistics – Suicides in England and Wales 2020

Years of life lost is a measure of premature mortality and gives an estimate of the length of time a person would have lived had they not died prematurely (Office for Health Improvement and Disparities, 2022). Years of life lost due to suicide has increased in England since the 2011-13 period (Figure 4.9) even though suicide rate has declined (Figure 4.7). This may be due to increases in overall life expectancy.

Figure 4.9: Years of life lost due to suicide by sex – 3-year average (England)



	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 - 17	2016 - 18	2017 - 19	2018 - 20
Male	49.5	50.2	49.9	48.9	47.1	47.8	50.2	51.5
Female	13.4	13.7	14.4	14.8	14.6	14.9	15.9	16.5
Persons	31.4	31.9	32.1	31.8	30.8	31.3	33	34

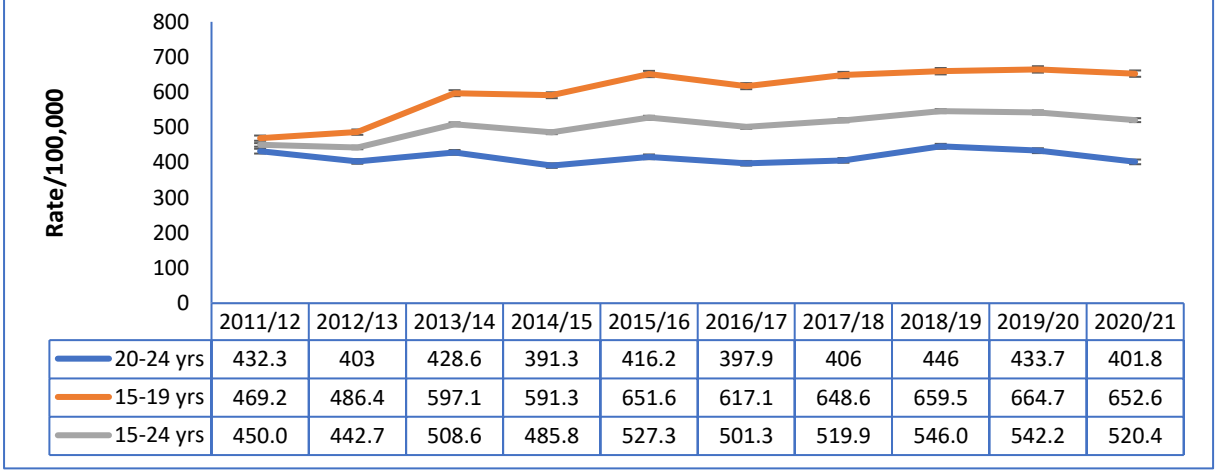
Source: ***OHID Fingertips (2022)***

4.6.1.2 National trends – Self-harm

Data presented in this section included those for children and young people but excludes those older than 24 years due to limitations related to data availability.

Self-harm events which are severe enough to warrant hospital admission are used as a proxy of the prevalence of severe self-harm, but these are only the tip of the iceberg in relation to the health and well-being burden of self-harm (Office for Health Improvement and Disparities, 2022). Overall, self-harm admissions rate in England has increased from 450.0/100,000 in 2011/12 to 520.4/100,000 in 2020/21. The increase was marked among those aged 15-19 years while there was a small decrease in the 15-19-year age group (Figure 4.10).

Figure 4.10: Trends for hospital admissions due to self-harm in England (2011/12 – 2020/21)



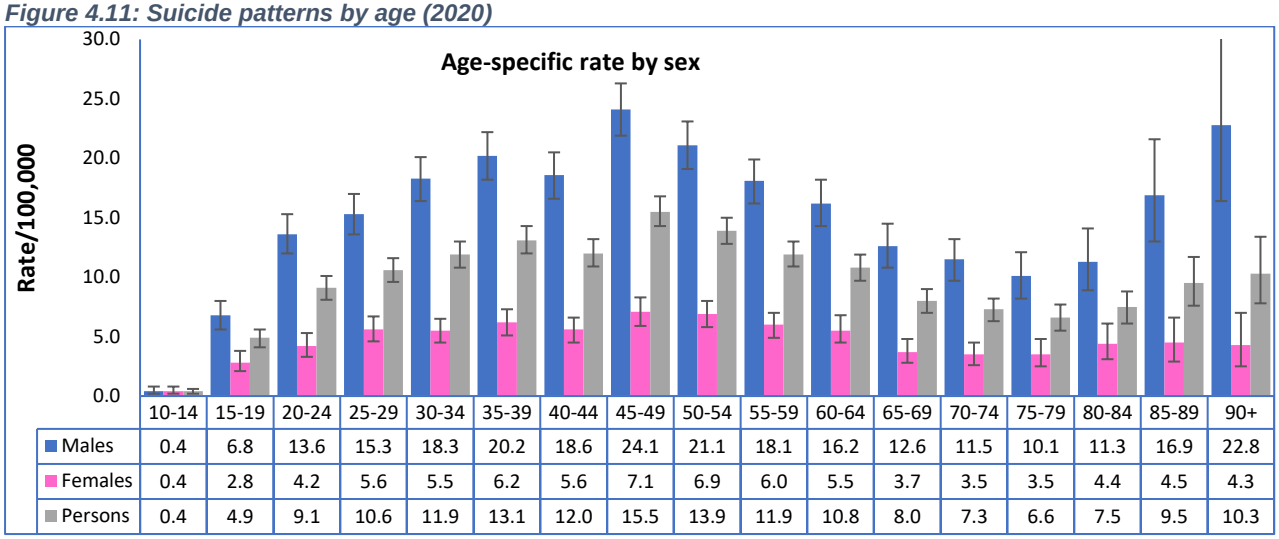
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
20-24 yrs	432.3	403	428.6	391.3	416.2	397.9	406	446	433.7	401.8
15-19 yrs	469.2	486.4	597.1	591.3	651.6	617.1	648.6	659.5	664.7	652.6
15-24 yrs	450.0	442.7	508.6	485.8	527.3	501.3	519.9	546.0	542.2	520.4

Source: ***OHID Fingertips (2022)***

4.6.1.3 Age and gender distribution - Suicide

Figure 4.11 shows suicide patterns by age and sex in England and Wales. Suicide rates were higher among men aged 45-49 years. Since the early 1980s rates in suicide by age have shown a consistent pattern, peaking among the middle-aged (40-54 years) before decreasing until the ages of 80-84, from which point they begin to rise again.

Figure 4.11: Suicide patterns by age (2020)



	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
Males	0.4	6.8	13.6	15.3	18.3	20.2	18.6	24.1	21.1	18.1	16.2	12.6	11.5	10.1	11.3	16.9	22.8
Females	0.4	2.8	4.2	5.6	5.5	6.2	5.6	7.1	6.9	6.0	5.5	3.7	3.5	3.5	4.4	4.5	4.3
Persons	0.4	4.9	9.1	10.6	11.9	13.1	12.0	15.5	13.9	11.9	10.8	8.0	7.3	6.6	7.5	9.5	10.3

Source: Office for National Statistics – Suicides in England and Wales 2020

The suicide rate in middle-aged men in the UK has been estimated to be 1.5 times greater than men in other age groups. Men living in the most deprived areas, from the lowest social class are up to ten times more likely to end their lives by suicide in comparison to those living in the most affluent areas and from the highest social class (Wyllie, et al., 2012).

A national study found the following relating to middle-aged men who died by suicide at the time of death (National Institute for Health Research, 2021):

- Almost a third (30%) were unemployed; of these, almost half had been unemployed for over 12 months (47%)
- 57% were experiencing economic problems such as finance, accommodation or unemployment
- Over a quarter (27%) lived in the most deprived areas in England
- 45% were reported as living alone
- 66% had a mental health diagnosis; over half of men with a mental health diagnosis also had a physical condition (56%)
- Physical health conditions were common (52%) and often chronic (33%)
- 36% reported a problem with alcohol misuse and 31% reported illicit drug use, 49% had either alcohol or drug misuse or both; this was particularly common for men who were unemployed, bereaved, and had a history of violence or self-harm
- 44% had a known history of self-harm

4.6.1.4 Age and gender distribution – Self-harm

Existing evidence shows that:

- Rates of deliberate self-injury are two to three times higher in women than men (Department of Health, 2011).
- Self-harming in young people is not uncommon (10-13% of 15-16-year-olds have self-harmed in their lifetime) (Department of Health, 2011).
- Older people who self-harm are more likely to do so in an attempt to end their life (Royal College of Psychiatrists, 2010).

4.6.1.5 Lifetime risk of suicidal thoughts, suicide attempts and self-harm

Table 4.3 shows the prevalence of self-reported lifetime risk of suicidal thoughts, suicide attempts and self-harm, by age and sex in England from the 2014 Adult Psychiatric Morbidity Survey (NHS Digital, 2016). Overall, 20.6% of adults aged 16 years or older reported that they had thought of taking their own life at some point, 6.7% reported attempting suicide at some point, while 7.3% reported having self-harmed at some point in their lives. Women tended to have higher prevalence of self-reported suicidal thoughts, suicide attempts and self-harming than men. The following were noted in the survey report (NHS Digital, 2016):

- The higher reporting of suicidal thoughts and attempts in people aged less than 65 might be explained by generational differences, with young people now being more likely to have suicidal thoughts than their counterparts in the past.
- While the overall pattern by age was not significantly different in men and women, the rate of suicide attempts reported by young women (aged 16 to 24) was notably high.
- The age gradient for self-harm was more pronounced with the younger age group being more likely to self-harm, and this was particularly evident in women

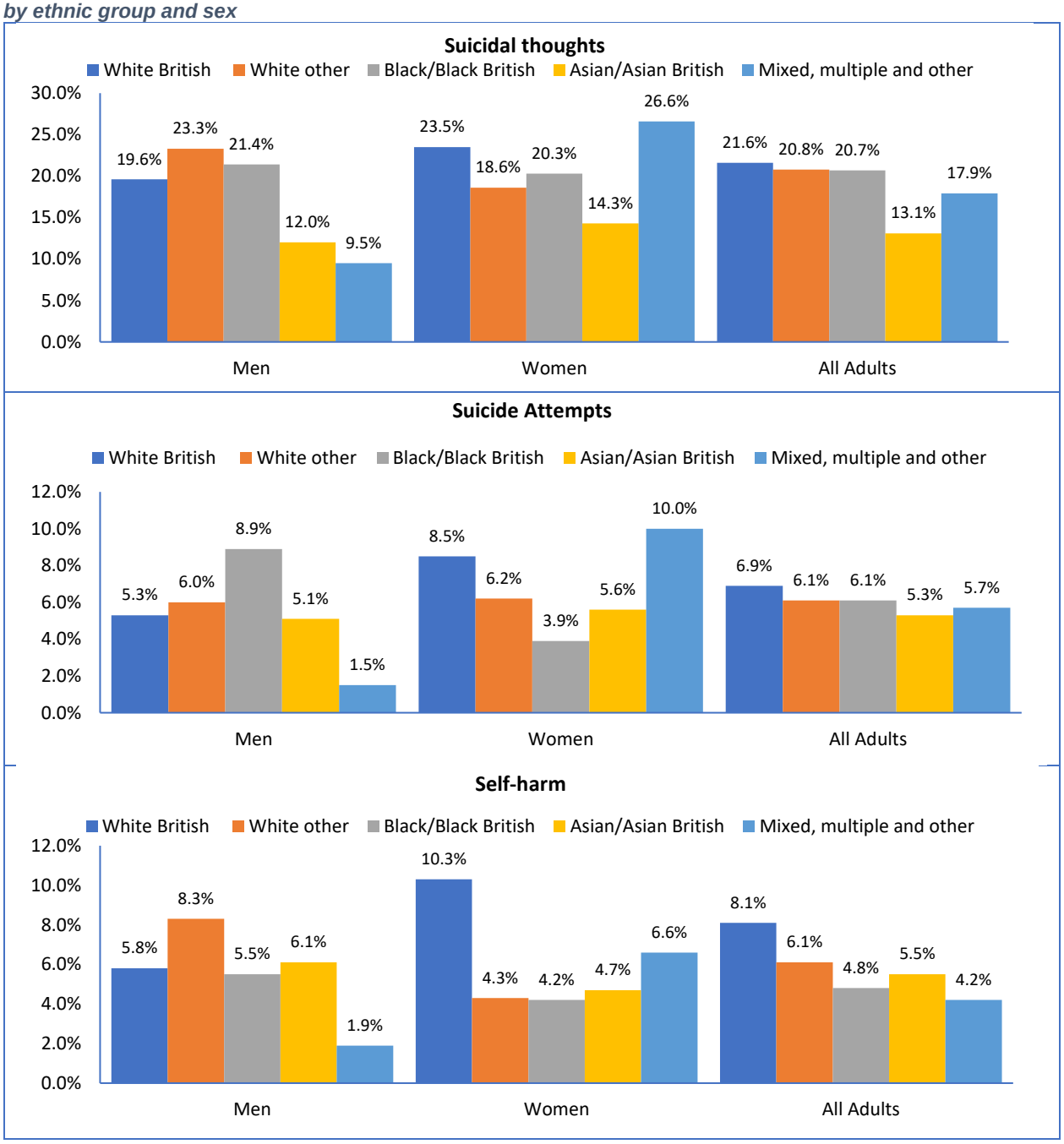
Table 4.3: Prevalence of self-reported lifetime suicidal thoughts, suicide attempts, and self-harm by age and sex

Category	Age							
	16-24	***25-34***	***35-44***	***45-54***	***55-64***	***65-74***	***75+***	***All***
Men								
Suicidal thoughts	19.3%	21.1%	21.1%	20.7%	22.5%	11.9%	7.1%	18.7%
Suicidal attempts	5.4%	8.0%	6.5%	5.4%	5.4%	3.5%	1.0%	5.4%
Self-harm	9.7%	10.9%	6.6%	3.3%	3.3%	2.0%	-	5.7%
Women								
Suicidal thoughts	34.6%	24.1%	22.8%	26.6%	22.9%	11.7%	8.8%	22.4%
Suicidal attempts	12.7%	9.1%	9.5%	8.2%	8.6%	3.7%	2.1%	8.0%
Self-harm	25.7%	13.2%	9.2%	5.0%	5.0%	1.8%	0.6%	8.9%
All adults								
Suicidal thoughts	26.8%	22.6%	21.9%	23.7%	22.7%	11.8%	8.1%	20.6%
Suicidal attempts	9.0%	8.5%	8.0%	6.8%	7.0%	3.6%	1.7%	6.7%
Self-harm	17.5%	12.1%	7.9%	4.1%	4.1%	1.9%	0.3%	7.3%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

The 2014 Adult Psychiatric Morbidity Survey (NHS Digital , 2016) report on suicidal thoughts, suicide attempts, and self-harm showed variations in the rates of reported suicidal thoughts, suicide attempt and self-harm by gender and ethnicity (Figure 4.12). However, the rates did not differ significantly by ethnic group after age-standardising the data. This may be due to sample size associated with the ethnic group categories, which are both small and heterogeneous, masking real differences (NHS Digital , 2016).

Figure 4.12: Age-standardised prevalence of lifetime suicidal thoughts, suicide attempts and self-harm, by ethnic group and sex



Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

People under the age of 60 years who lived on their own were more likely to have suicidal thoughts than those of the same age living with others. This was also true of having made a suicide attempt and of having self-harmed. Of people living in such circumstances, 40.2% had suicidal thoughts, compared with 24.8% of people who lived with another adult. This pattern was also evident in people aged 60 years or over: those living alone were more than twice as likely to have made a suicide attempt as those living with another person (6.4%, compared with 2.5%) (NHS Digital , 2016). Generally, the lifetime risks were higher among women (Table 4.4).

Table 4.4: Prevalence of lifetime suicidal thoughts, suicide attempts and self-harm, by household type and sex

Category	Household type						
	1 adult aged 16-59, no children	*2 adults 16-59, no children*	*Small family*	*Large family*	*Large adult household*	*2 adults, 1 + aged 60+, no children*	*1 adult 60+, no children*
Men							
Suicide thoughts	39.5%	21.1%	13.4%	14.0%	19.5%	10.3%	18.0%
Suicide attempts	14.6%	5.6%	3.4%	5.8%	5.6%	1.9%	6.0%
Self-harm	14.0%	8.3%	4.3%	7.1%	5.5%	1.0%	1.7%
Women							
Suicide thoughts	41.3%	28.3%	22.6%	21.0%	23.0%	12.5%	14.9%
Suicide attempts	17.9%	9.5%	7.7%	6.9%	8.8%	3.1%	6.6%
Self-harm	16.0%	12.4%	11.0%	9.8%	10.0%	2.0%	2.8%
All adults							
Suicide thoughts	40.2%	24.8%	18.6%	18.0%	21.1%	11.4%	15.9%
Suicide attempts	16.0%	7.6%	5.8%	6.4%	7.0%	2.5%	6.4%
Self-harm	14.9%	10.4%	8.1%	8.6%	7.5%	1.5%	2.4%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

The survey found employment status was associated with suicidal thoughts, suicide attempts and self-harm in the working-age population (16- to 64-year-olds). Among men, the associations were strong, with rates of each lowest among the employed and highest in the economically inactive. In women the differences were less marked, with similar rates in the unemployed and those who were economically inactive (Table 4.5).

Table 4.5: Age-standardised prevalence of lifetime suicidal thoughts and suicide attempts, by employment status and sex

Category	Employment status		
	Employed	Unemployed	Economically inactive
Men			
Suicide thoughts	18.2%	25.9%	38.7%
Suicide attempts	3.9%	9.6%	20.3%
Self-harm	5.3%	9.6%	12.4%
Women			
Suicide thoughts	23.7%	36.5%	30.8%
Suicide attempts	8.1%	13.6%	13.3%
Self-harm	10.3%	14.6%	14.2%
All adults			
Suicide thoughts	20.8%	30.5%	34.0%
Suicide attempts	5.8%	11.3%	16.1%
Self-harm	7.6%	12.6%	14.6%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

The 2014 Adult Psychiatric Morbidity Survey (NHS Digital , 2016) showed 66.4% of people in receipt of Employment and Support Allowance (ESA) reported thoughts about taking their life, 43.2% had made a suicide attempt and 33.5% reported self-harming indicating that this is a population in greater need of support. People in receipt of other benefits also had higher rates of suicidal thoughts, suicide attempts and self-harm than those who did not receive these benefits (Table 4.6).

Table 4.6: Lifetime suicidal thoughts, suicide attempts and self-harm (age-standardised), by benefit status and sex

Category	Benefit status					
	Employment and Support Allowance (all aged 16-64)		*Any out-of-work benefit (all aged 16-64)*		*Household in receipt of housing benefit (all aged 16+)*	
Men	***Yes***	***No***	***Yes***	***No***	***Yes***	***No***
Suicide thoughts	62.9%	18.9%	47.1%	18.1%	39.3%	17.1%
Suicide attempts	40.5%	4.9%	23.8%	4.5%	20.6%	4.2%
Self-harm	30.2%	6.0%	17.7%	5.7%	14.9%	4.9%
Women						%
Suicide thoughts	71.4%	24.5%	50.6%	23.5%	36.3%	20.5%
Suicide attempts	47.1%	8.3%	30.6%	7.5%	19.4%	6.5%
Self-harm	38.2%	10.6%	24.7%	10.0%	15.5%	8.2%
All adults						
Suicide thoughts	66.4%	21.6%	48.9%	20.8%	37.4%	18.8%
Suicide attempts	43.2%	6.6%	27.2%	5.9%	19.9%	5.4%
Self-harm	33.5%	8.2%	21.2%	7.8%	15.3%	6.5%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

4.6.1.6 Methods and reasons for self-harm

The 2014 Adult Psychiatric Morbidity Survey (NHS Digital , 2016) showed overall, 73.1% of people who self-harmed had cut themselves, 10.2% had burned themselves, 13.8% swallowed something and 29.1% had used some other method. While women were more likely than men to report cutting (77.0%, compared with 66.2% of men), men were more likely than women to have burned themselves - 16.8% of men compared with 6.5% of women had burned themselves (Table 4.7).

The survey also showed 76.7% of people who had self-harmed cited relieving unpleasant feelings of anger, tension, anxiety or depression as a reason for doing so, while 31.0% reported self-harming in order to draw attention to or to change their situation. Women were more likely than men to agree with at least one of these reasons (Table 4.7).

Table 4.7: Methods and reasons for self-harming, by sex

Category	Sex		
Method of self-harming	***Male***	***Female***	***Total***
Cut self	66.2%	77.0%	73.1%
Burned self	16.8%	6.5%	10.2%
Swallowed something	17.1%	11.9%	13.8%
Harmed self in other way	32.2%	27.4%	29.1%
Reasons harmed self			
To draw attention	23.8%	35.0%	31.0%
To relieve unpleasant feelings	66.8%	82.1%	76.7%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

Methods of self-harming also varied with age. Those aged 16-34 years were more likely than their older counterparts to report cutting or burning themselves, whereas older people were more likely to report swallowing something or some other method (Table 4.8). It was also more common for 16-34-year-olds to report more than one method, compared with those aged 35 or more.

There was an association between reasons for self-harming and age. Younger people were more likely than older people to report that they self-harm in order to relieve unpleasant feelings, while older people were more likely than younger people to report self-harming in order to draw attention (Table 4.8).

Table 4.8: Methods and reasons for self-harming, by age

Category	Age		
	16-34	***35-54***	***55+***
Method of self-harming			
Cut self	84.3%	58.3%	39.5%
Burned self	12.3%	7.9%	2.2%
Swallowed something	11.2%	14.9%	28.2%
Harmed self in other way	23.8%	38.8%	37.5%
Reasons harmed self			
To draw attention	28.6%	33.8%	40.0%
To relieve unpleasant feelings	81.9%	71.5%	55.7%

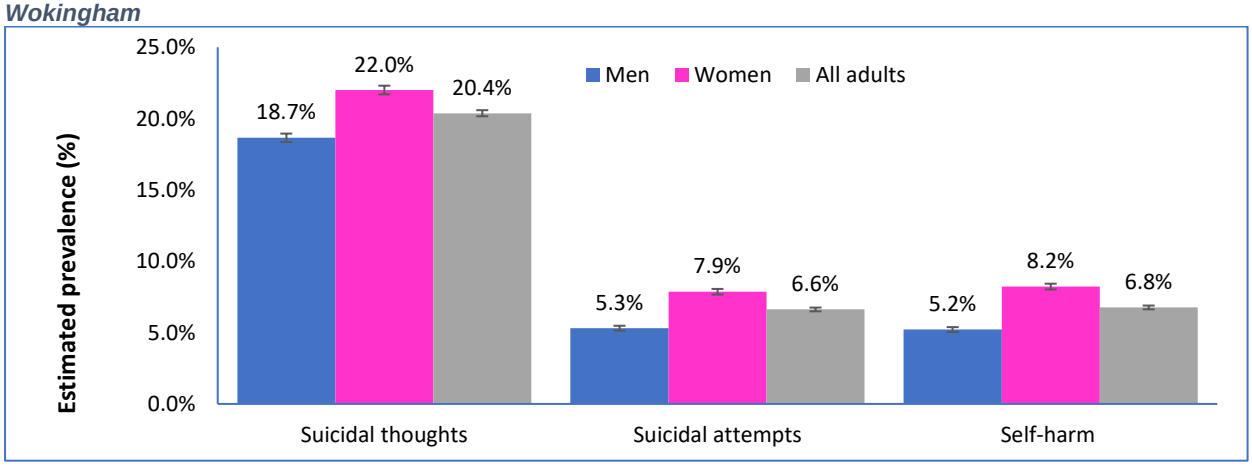
Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

4.6.2 Wokingham self-harm and suicide profile

4.6.2.1 Lifetime risk of suicidal thoughts, suicide attempts and self-harm in Wokingham

Assuming the Adult Psychiatric Morbidity Survey (NHS Digital, 2016) findings (see Table 4.3) were applicable to Wokingham, we estimated in 2020 20.4% of all adults aged 16 years or older would have experienced suicidal thoughts at any point in their lives - the respective estimate for suicide attempts and self-harm are 6.6% and 6.8% (Figure 4.13).

Figure 4.13: Estimated prevalence of lifetime suicidal thoughts, suicide attempts and self-harm in Wokingham

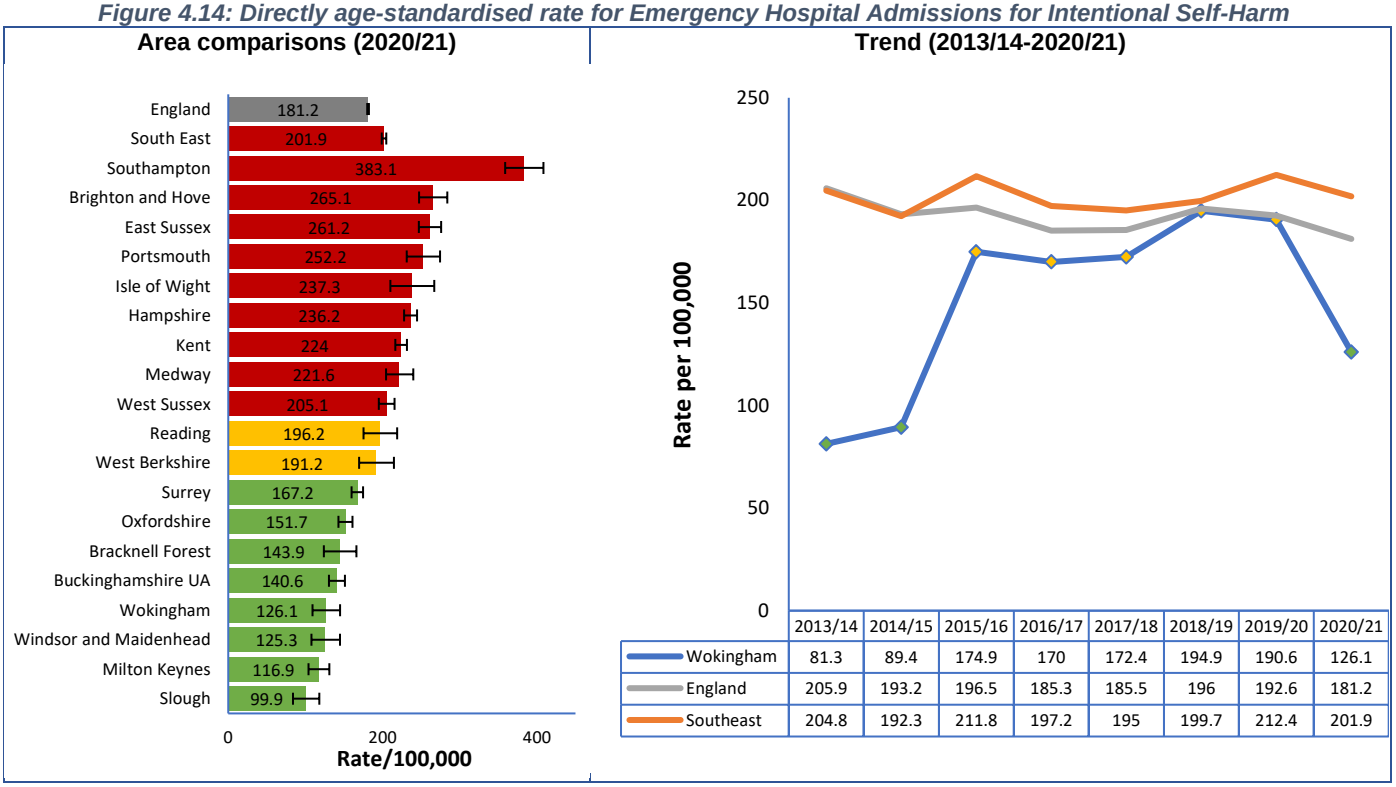


Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016) ***and ONS 2020 Mid-year Population Estimate***

4.6.2.2 Self-harm prevalence in Wokingham

In 2020/21 there were 205 emergency hospital admissions for self-harm across all ages in Wokingham. This was equivalent to an age-standardised rate 126.1 per 100,000 making Wokingham the 4th lowest in the South East significantly below the regional and England averages (Figure 4.14). There was a significant decrease in Wokingham rate between 2019/20 and 2020/21 (Figure 4.14). This was likely to have been influenced by the COVID-19.

Figure 4.14: Directly age-standardised rate for Emergency Hospital Admissions for Intentional Self-Harm



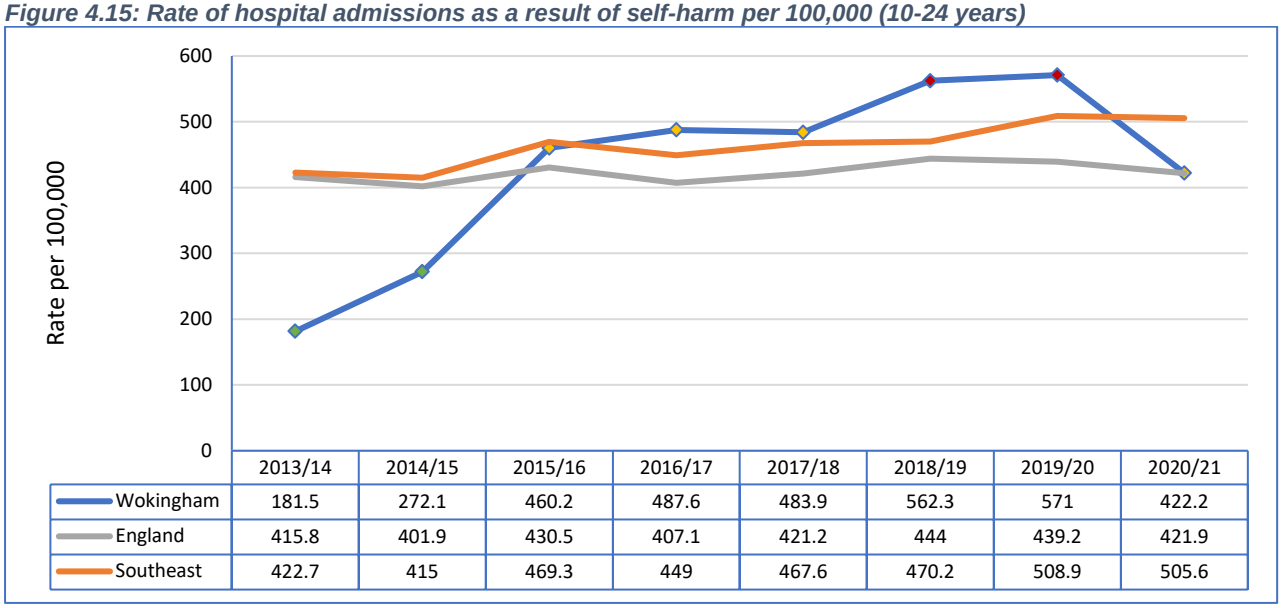
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Wokingham	81.3	89.4	174.9	170	172.4	194.9	190.6	126.1
England	205.9	193.2	196.5	185.3	185.5	196	192.6	181.2
Southeast	204.8	192.3	211.8	197.2	195	199.7	212.4	201.9

Source: *Fingertips* (Office for Health Improvement and Disparities, 2022)

Figure 4.15 shows the rate per 100,000 of hospital admissions from self-harm in young people aged 10 to 24 years in England, Southeast England and Wokingham. Until the most recent data in 2020/21, this was showing an upward trend in episodes of admission for all regions. In 2019/20 the rate of admission among Wokingham young people was significantly worse compared to England and the South East, however, there has been a noticeable decline in the following year making Wokingham's rate similar to England estimates.

This data was based on admission episodes – a person may be admitted on multiple occasions during each period. Indicators based on hospital admission episode may be influenced by local variation in referral and admission practices as well as variation in incidence. Additionally, the data did not include attendances at Accident and Emergency which do not result in an admission.

Figure 4.15: Rate of hospital admissions as a result of self-harm per 100,000 (10-24 years)

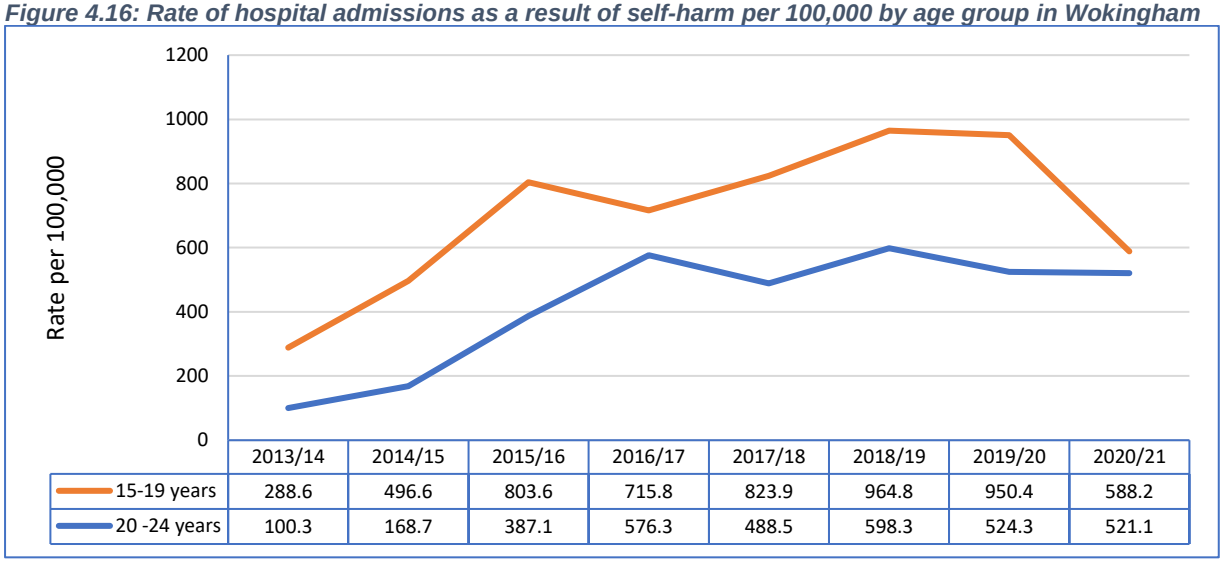


	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Wokingham	181.5	272.1	460.2	487.6	483.9	562.3	571	422.2
England	415.8	401.9	430.5	407.1	421.2	444	439.2	421.9
Southeast	422.7	415	469.3	449	467.6	470.2	508.9	505.6

Source: (NHS Digital , 2016)

Further data on rates of hospital admissions as a result of self-harm by age groups is shown in Figure 4.16. The data is presented for those between the ages 15 to 19 years and 20 to 24 years. As shown, admissions are consistently highest in children and young people aged 15-19-year-old age band in Wokingham.

Figure 4.16: Rate of hospital admissions as a result of self-harm per 100,000 by age group in Wokingham

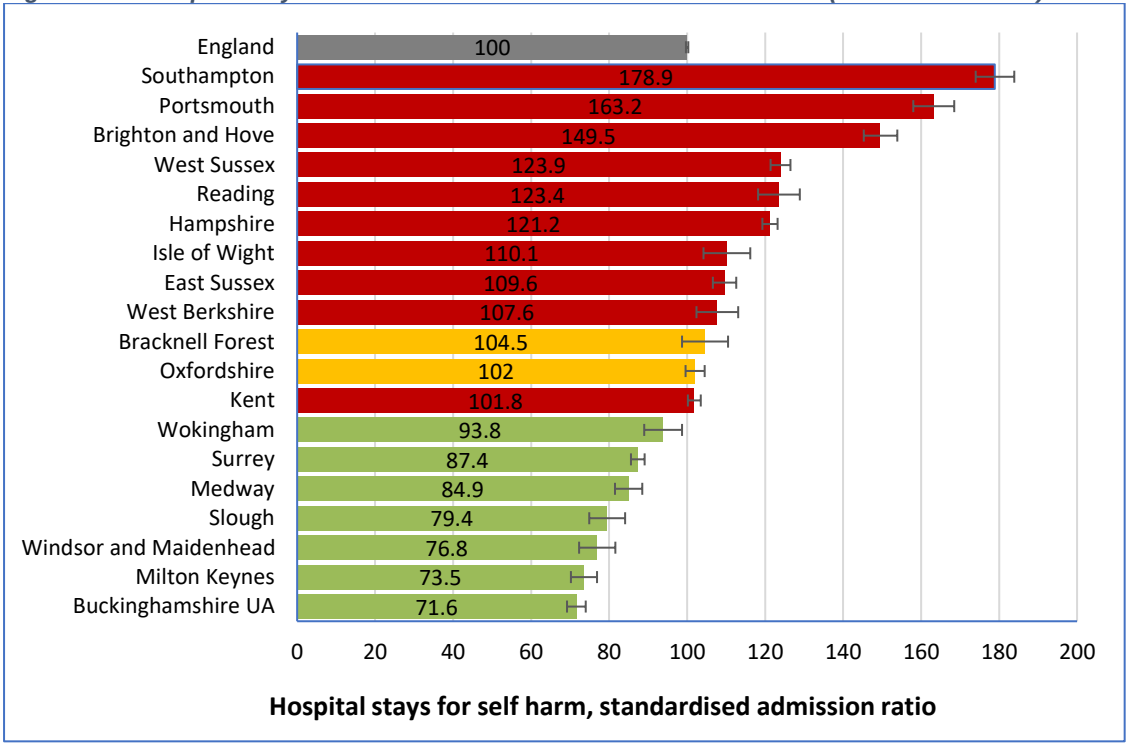


	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
15-19 years	288.6	496.6	803.6	715.8	823.9	964.8	950.4	588.2
20 -24 years	100.3	168.7	387.1	576.3	488.5	598.3	524.3	521.1

Source: (NHS Digital , 2016)

Between 2015/16 and 2019/20 Wokingham residents were 6.2% less likely to be admitted to hospital due to self-harm compared with the England average and it was the 7th lowest in the South East (Figure 4.17).

Figure 4.17: Hospital stays for self-harm – standardised admission ratio (2015/16 – 2019/20)

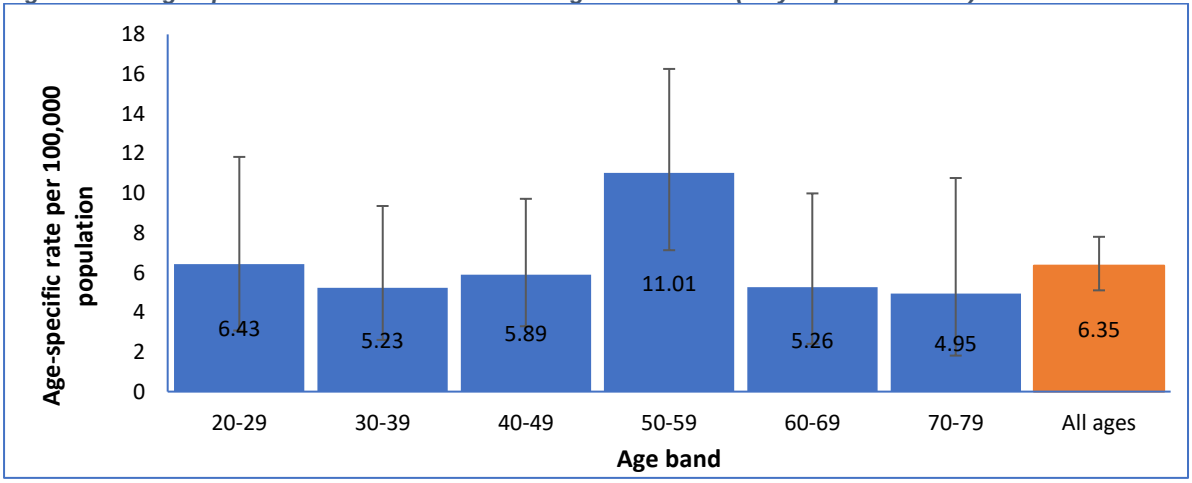


Source: ***Fingertips*** (Office for Health Improvement and Disparities, 2022)

4.6.2.3 Suicide prevalence in Wokingham

There were 90 suicide deaths in Wokingham between 2011 and 2020 giving an overall suicide rate of 6.3 per 100,000 over the period. The highest rate of 11 per 100,000 was observed among those aged 50-59 years while the lowest of 4.9 per 100,000 was among those aged 70-79 years (Figure 4.18). These differences were not significant across the various age groups due to small numbers of deaths in each age group.

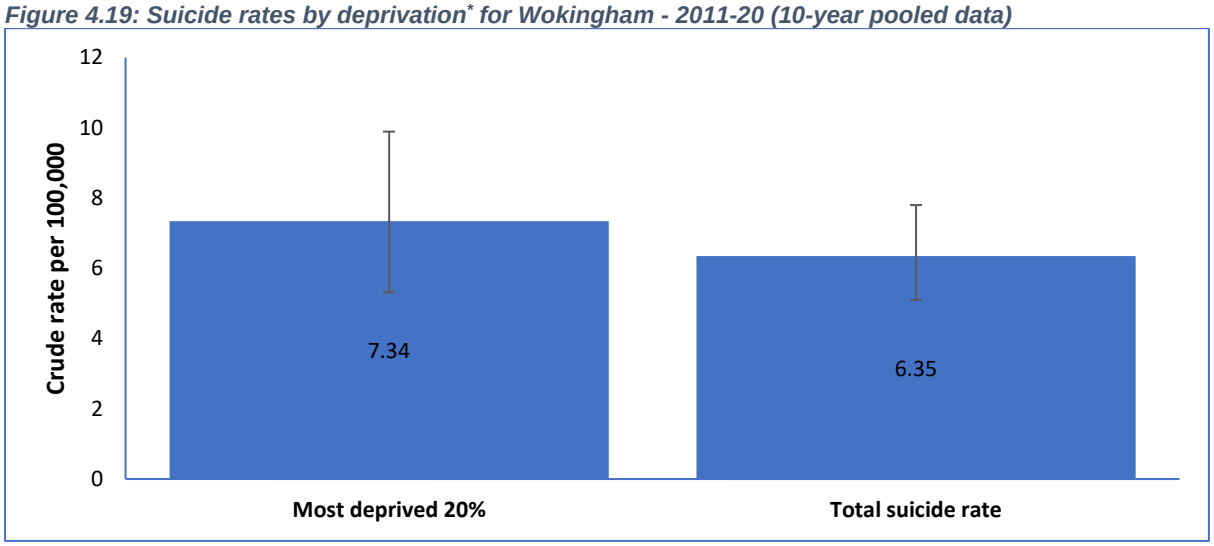
Figure 4.18: Age-specific Suicide Rates for Wokingham 2011-20 (10-year pooled data)



Source: ONS Civil Registrations Data provided under license by NHS Digital

Though the death rate was higher among those living the 20% most deprived areas compared with the Wokingham average (7.3 compared with the average of 6.3 per 100,000) the difference was not significant (Figure 4.19).

Figure 4.19: Suicide rates by deprivation for Wokingham - 2011-20 (10-year pooled data)*



Source: ONS Civil Registrations Data provided under license by NHS Digital

The most common occupational group with suicide deaths was Skilled Trades Occupations (15 out of the 90 deaths) while those in Caring, Leisure and Other Service Occupations has the lowest number of 5 out of the 90 deaths (Table 4.9). It is not possible to make any association between the number of deaths and occupation as we could not calculate rates for comparison.

Table 4.9: Distribution of suicide deaths in Wokingham by major occupational group - 2011-20 (10-year pooled data)

Major Occupation Group	Deaths from suicide and injury of undetermined intent 2011-20	%
Associate Professional Occupations	12	13.3%
Caring, Leisure and Other Service Occupations	5	5.6%
Managers, Directors and Senior Officials	6	6.7%
Process, Plant and Machine Operatives	9	10.0%
Professional Occupations	14	15.6%
Skilled Trades Occupations	15	16.7%
Others†	29	32.2%
TOTAL DEATHS	**90**	**100.0%**

* Deprivation deciles use are based on local IMD scores

† This includes: Sales and Customer Service Occupations, Student, Elementary Occupations, Administrative and Secretarial Occupations

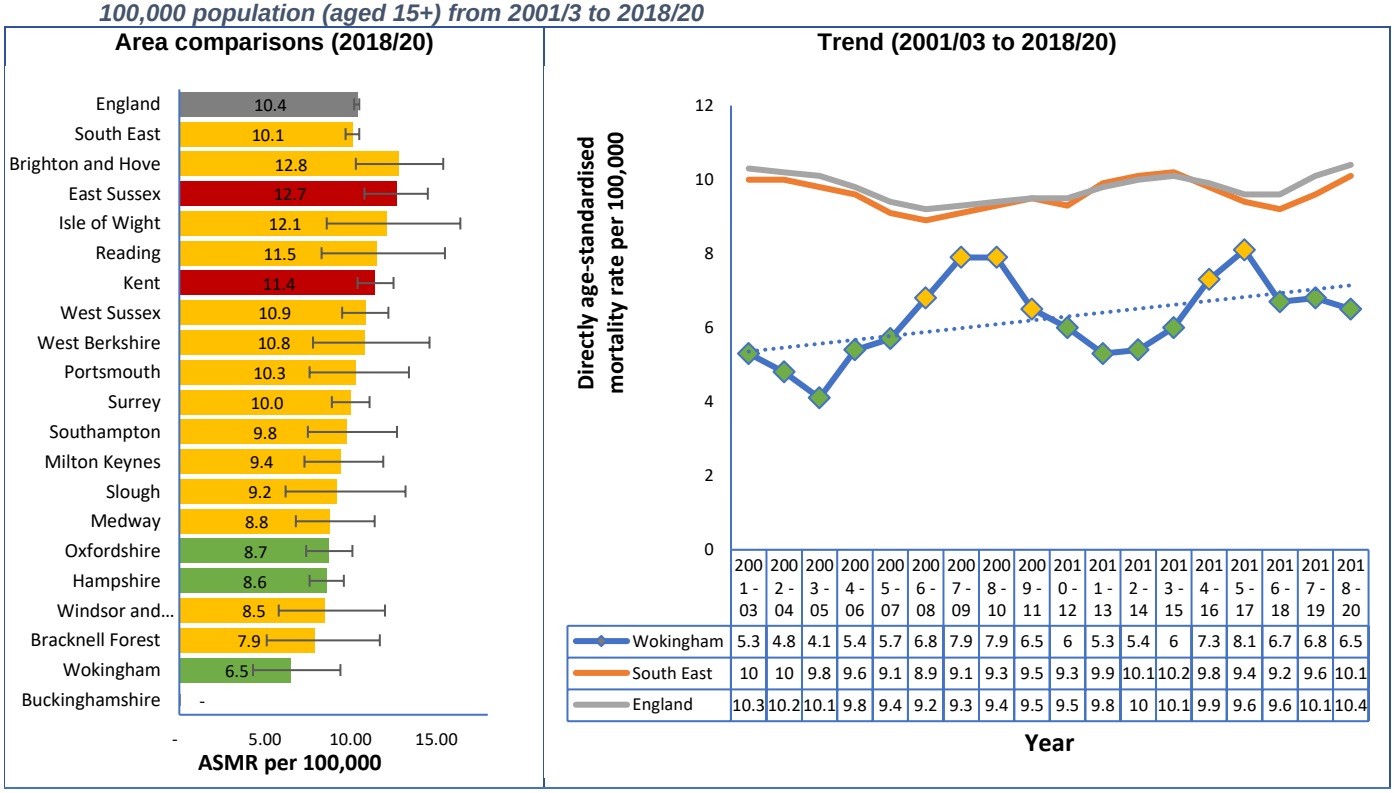
Age-standardised mortality rate (ASMR) adjust for differences in structure and are used for comparisons between populations that may contain different overall population age structures.

In 2018-2020 (the most recent data available at the time of writing this needs assessment), compared to the England age-standardised mortality rate from suicide and injury of undetermined intent of 10.4 per 100,000, Wokingham has a rate of 6.5 per 100,000 population.

The ASMR in Wokingham shows a slight upward trend from 2001-2003 though the increase is not statistically significant – the most recent trend was however downward. Regional and national most recent trend data showed a slight upward trend. Rates in Wokingham are consistently below the regional and national averages over the 2001-2003 to 2018-2020 period (Figure 4.20) (Office for Health Improvement and Disparities, 2022).

It must be noted that the COVID-19 pandemic has had an impact on the recording of suicides by coroners due to delays to inquests, so we may not have had the complete picture for 2020 statistics.

Figure 4.20: Directly age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 15+) from 2001/3 to 2018/20

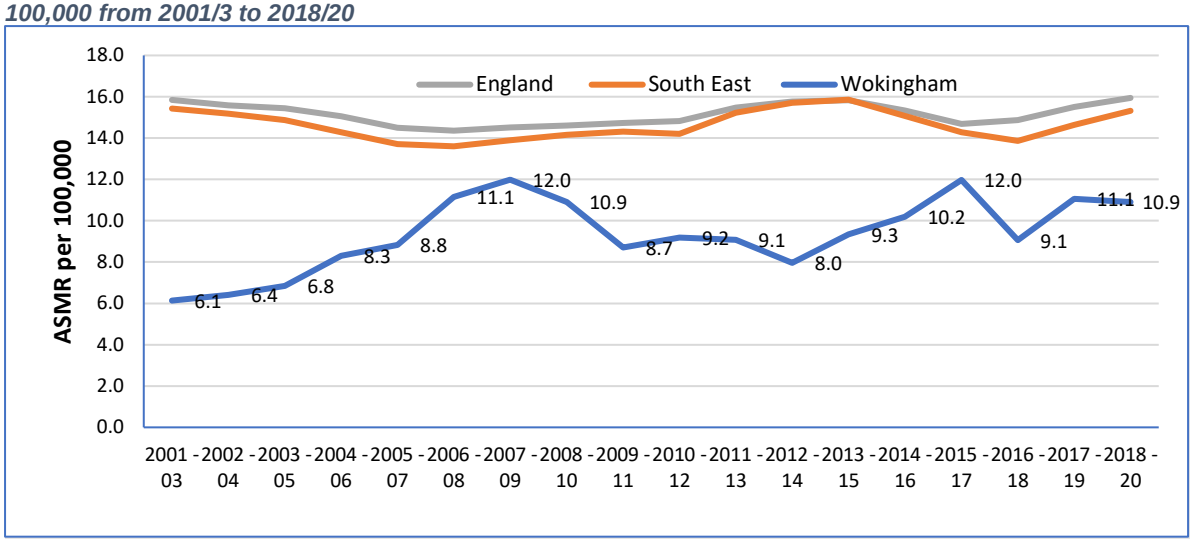


Source: (Office for Health Improvement and Disparities, 2022)

Figure 4.21 shows the male suicide rate across England, the Southeast and Wokingham. In England, three quarters of all suicides are male suicides. In Wokingham between 2018 and 2020, the male age-standardised suicide rate was 10.9 per 100,000 which is lower than the rate for England (15.9 per 100,000) and lower than the rate for the Southeast (15.3 per 100,000). It is again important to note,

we do not have the complete picture for 2020 statistics due to delays in inquests so cannot see if/how Covid-19 affected suicide rates in Wokingham.

Figure 4.21: Age-standardised mortality rate from suicide and injury of undetermined intent in men per 100,000 from 2001/3 to 2018/20



Source: (Office for National Statistics , 2021)

Age-standardised mortality rates can only be calculated for local authority areas where there are 10 or more suicides. Between 2018 - 2020 there were fewer than 10 suicides in women for Wokingham and therefore there was no rate available to compare. The female age-standardised suicide rate in England for the same period was 5.0 per 100,000 and similar to the rate for the South East which was 5.2 per 100,000.

4.7 Service Model/s and Prevention

4.7.1 Seeking help after suicide attempt or self-harm episode

The 2014 Adult Psychiatric Morbidity Survey (NHS Digital , 2016) showed that following self-harm episodes, 37.7% of those affected received medical and/or psychological help; men were less likely to have received help than women. The preferred type of help received was psychological (Table 4.10).

Table 4.10: Whether received medical and/or psychological help after self-harm, by sex

Type of help received	Sex		
	Male	Female	Total
Medical help	16.2%	29.2%	24.6%
Psychological help	24.0%	38.1%	33.1%
Received medical and/or psychiatric help	27.8%	43.1%	37.7%
Neither medical nor psychiatric help received	**72.2**%	**56.9**%	**62.3**%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

There was also an age-gradient with the older age groups tending to seek medical and/or psychiatric help after self-harming episode compared with the younger ones. 52.9% those aged 55 or over who had self-harmed obtained medical and/or psychiatric help at some point while the figures for the those aged 16-34 and 35-54 years were 33.1% and 43.3% respectively (Table 4.11).

Table 4.11: Whether received medical and/or psychological help after self-harm, by age

Type of help received	Age		
	16-34	35-54	55+
Medical help	21.2%	27.9%	38.9%
Psychological help	29.7%	37.5%	44.0%
Medical and/or psychiatric help	33.1%	43.3%	52.9%
Neither medical nor psychiatric help received	**66.9**%	**56.7**%	**47.1**%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

The 2014 Adult Psychiatric Morbidity Survey (NHS Digital , 2016) also showed just over 50% of those who attempted suicide sought help from at least one source following their last suicide attempt – men were less likely than females to seek help - 47.1% of men sought help compared with 51.9% of women (Table 4.12). The preferred source of help sought was from a GP.

Table 4.12: Sources sought help from following last suicide attempt, by sex

From whom sought help	Sex		
	Male	Female	Total
GP/family doctor	25.9%	26.7%	26.4%
Hospital/specialist medical or psychiatric service	22.9%	27.1%	25.5%
Friends/family/neighbours	21.6%	21.8%	21.7%
Someone else	2.9%	1.1%	1.8%
Sought help from at least one source	**47.1**%	**51.9**%	**50.1**%
Did not seek help	52.9%	48.1%	49.9%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

Those aged 55 years or older were more likely to seek support compared with the younger age groups (55.0% compared to 48.4% and 48.5% among those aged 16-34 and 35-54 years respectively) (Table 4.13).

Table 4.13: Sources sought help from following last suicide attempt, by age

From whom sought help	Age		
	16-34	35-54	55+
GP/family doctor	29.1%	24.9%	23.9%
Hospital/specialist medical or psychiatric service	20.8%	27.5%	30.5%
Friends/family/neighbours	29.9%	18.3%	12.9%
Someone else	1.1%	1.5%	3.6%
Sought help from at least one source	**48.4**%	**48.8**%	**55.0**%
Did not seek help	51.6%	51.2%	45.0%

Source: Adult Psychiatric Morbidity Survey (NHS Digital, 2016)

4.7.2 The Berkshire Suicide Prevention Strategy 2021-2026

The Berkshire Suicide Prevention Strategy 2021-2026 has the vision for the main aim to reduced deaths by suicide in Berkshire across the life course and ensure better knowledge and action around self-harm. Recommendations in the strategy include:

- To undertake a Berkshire suicide audit
- Undertake regular reviews of information, resources and channels for people affected by suicide
- Set up sub-groups of the Suicide Prevention Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population
- Working with Mental Health Support Teams, ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm
- Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.
- Raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public

4.7.3 Summary of the main findings

4.7.3.1 Prevalence of risk factors

- Children in need referral rate is below the regional and national averages but has seen a steep rise between 2017 and 2020
- Overall, the looked after children rate has seen a slight decline between 2018 and 2020 while regional and national patterns showed slight upward trends. The local rate has been significantly lower than both the regional and national rates over the period.
- The proportion of children leaving in relative poverty in significantly below regional and national averages, but this has increased from 5.5% in 2014/15 to 7.2% in 2019/20.
- Unemployment levels among the local population has risen in the recent period preceding the development of the needs assessment to levels similar to the national average.

4.7.3.2 Self-harm

- In 2020/21 there were 205 emergency hospital admissions for self-harm across all ages in Wokingham equivalent to an age-standardised rate 126.1 per 100,000 significantly below the regional and England averages
- Between 2015/16 and 2019/20 Wokingham residents were 6.2% less likely to be admitted to hospital due to self-harm compared with the England average and it is the 7th lowest in the South East

4.7.3.3 Suicide

- There were 90 suicide deaths in Wokingham between 2011 and 2020, an overall pooled suicide rate of 6.3 per 100,000 over the period

- The highest rate was observed among those aged 50-59 years while the lowest rate was among those aged 70-79 years
- Though the death rate was higher among those living the 20% most deprived areas compared with the Wokingham average the difference was not significant
- The most common occupational group with suicide deaths was Skilled Trades Occupations
- Though the age-standardised mortality rates in Wokingham showed a slight upward trend from 2001-2003 the most recent trend was however downward. Regional and national most recent trend data show a slight upward trend. Rates in Wokingham are consistently below the regional and national averages over the 2001-2003 to 2018-2020 period
- Estimate based on Adult Psychiatric Morbidity Survey showed 20.4% of all adults aged 16 years or older would have experienced suicidal thoughts at any point in their lives - the respective estimate for suicide attempts and self-harm are 6.6% and 6.8%

4.7.3.4 Service use

Though there were not local data on service use patterns, national survey data showed:

- Following self-harm episodes, 37.7% of those affected received medical and/or psychological help; men were less likely to have received help than women. The preferred type of help received was psychological
- Those aged 55 or over who had self-harmed were most likely to obtained medical or psychological help at some point while the figures for the those aged 16-34 were least likely.
- Just over 50% of those who attempted suicide sought help from at least one source following their last suicide attempt – men were less likely than females to seek help compared with women. The preferred source of help sought was from a GP.
- Those aged 55 years or older were more likely to seek support compared with the younger age groups

4.8 Conclusion and consideration

Suicide is devasting and has a far-reaching impact, on the individual, family, friends, and the wider community. Though Wokingham has a comparably lower rate of suicide and self-harm compared with regional and national averages, there were indications of slight upward trends in their prevalence and prevalence of some of the risk factors e.g., unemployment rate

Generally, men are less likely seek help following episodes of self-harm and suicide attempts though they remain more prone to suicide deaths compared to women. Efforts to reduce the incidence of these event should take due cognisance for these tendencies.

Evidence from a systematic review showed that contact with primary health care prior to suicide is common even in the final month before death and this highlights the importance of placing suicide prevention strategies and interventions within the primary health care setting (Stene-Larsen & Reneflot, 2019).

The implementation of the Berkshire Suicide Prevention Strategy, being overseen by the Berkshire Suicide Prevention Steering Group, should consider establishing effective partnerships to address the underlying risk factors, raise awareness among residence and professional groups and improve access to effective mental health support. Additionally, emphasis should be laid on involvement of primary care in identifying cases, based assessment of some of the risk factors, being more sensitive to high-risk situations in depressed patients, and assessment of suicidal ideation and behaviour in patients being treated for depression (Schreiber & Culpepper, 2022).

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