**Office for National Statistics (ONS) 2018 Suicide Statistics release for Wales**

**Breakfast Briefing**

**02/10/2019 – 8:30-9:30am**

Samaritans Cymru vision is that fewer people die by suicide. Suicide is not inevitable; it is preventable. The causes of suicide are complex, but we know it is both a gender and an inequality issue. Behind every statistic is an individual, a family and a community devastated by their loss.

Suicide statistics for the UK as a whole, England, Wales, Scotland, Northern Ireland and the Republic of Ireland are not routinely published together by any other organisation.

**Agenda**

1) Latest suicide statistics 2018 - Office for National Statistics (ONS)

2) Wider policy issues for Wales

3) Suicide prevention in Wales – What do we want to see?

## 1) Latest suicide figures for the United Kingdom and Republic of Ireland (ROI)

- There were 6,859 suicides in the UK and the Republic of Ireland.
- The suicide rate in Scotland is the highest in the UK – where men aged 35-44 have the highest suicide rate.
- The highest suicide rate in England is among men aged 45-49.
- The highest suicide rate in the Republic of Ireland is among men aged 55-64.
- The highest suicide rate in Wales is among men aged 40-44.

## Key trends (2018) for the United Kingdom and Republic of Ireland (ROI)

- There has been a significant increase in suicide in the UK, the first time since 2013 – this appears to be driven by an increase in the male suicide rate.
- In the UK, suicide rates among young people (15-24) have been increasing in recent years. The suicide rate for young females is now at its highest rate on record.
- In the UK, men remain three times more likely to take their own lives than women, and in the Republic of Ireland four times more likely.

**Latest suicide figures for Wales**

Whilst the causes of suicide are complex, there are many risk factors which increase the risk of suicidal ideation and completed suicide and high-risk groups who are more likely to be subject to these risk factors. At Samaritans Cymru, we believe effective suicide prevention must be based on prevention and early intervention so we can minimize the amount of people who reach crisis point at the other end of the scale. We must embed a public health approach to suicide by placing a primary focus on prevention rather than cure alone. Investment in prevention and early intervention can reduce human, social and economic costs. In Wales, suicide is a major public health issue, but significantly, it is also a major inequality issue.

- 349 people took their own life in 2018
- 252 (72%) were men and 97 (28%) were women
- Compared to 2017, the suicide rate for 2018 decreased by 3%
- The male suicide rate decreased by 8.6% between 2017 and 2018.
- The female suicide rate increased by 19% between 2017 and 2018.
- Men aged 40-44 currently have the highest suicide rate.
- The male suicide rate is almost three times higher than the female.

## 2) Wider policy issues in Wales

### Socioeconomic disadvantage and suicidal behaviour

Wales has the third highest poverty rate in the UK which equates to almost one in four people living in poverty – the proportion and numbers of people living in relative poverty in Wales has not changed since 2006/7. (*Prosperity without poverty: a framework for action in Wales* / Joseph Rowntree Foundation 2016) Many local authorities with the highest levels of deprivation continue to have higher levels of suicide each year.

There is now overwhelming evidence of a strong connection between socioeconomic deprivation and suicidal behaviour. Areas of higher socioeconomic disadvantage tend to have higher rates of suicide and the greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour.

In 2016, Samaritans commissioned eight leading social scientists to review and extend the existing body of knowledge on the connection between socioeconomic disadvantage and suicidal behaviour in the United Kingdom.

**Key Findings**

- Suicide risk increases during periods of economic recession, particularly when recessions are associated with a steep rise in unemployment, and this risk remains high when crises end, especially for individuals whose economic circumstances do not improve.

- Social and employment protection for the most vulnerable in society, and labour market programmes to help unemployed people find work, can reduce suicidal behaviour by reducing both the real and perceived risks of job insecurity and by increasing protective factors, such as social contact. In order to be effective, however, programmes must be meaningful to participants and felt to be non-stigmatising.

- There is a strong association between area-level deprivation and suicidal behaviour: as area-level deprivation increases, so does suicidal behaviour. Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent.

- Admissions to hospital following self-harm are two times higher in the most deprived neighbourhoods compared to the most affluent.

- Multiple and large employer closures resulting in unemployment can increase stress in a local community, break down social connections and increase feelings of hopelessness and depression, all of which are recognised risk factors for suicidal behaviour.
- Individuals experiencing socioeconomic disadvantage and adverse experiences, such as unemployment and unmanageable debt, are at increased risk of suicidal behaviour, particularly during periods of economic recession.

- The risk of suicidal behaviour is increased among those experiencing job insecurity and downsizing or those engaged in non-traditional work situations, such as part-time, irregular and short-term contracts with various employers.

- The experience of being declared bankrupt, losing one's home or not being able to repay debts to family and friends is not only stressful but can also feel humiliating. This can lead to an increased risk of suicidal behaviour.

- The risk of suicidal behaviour increases when an individual faces negative life events, such as adversity, relationship breakdown, social isolation, or experiences stigma, emotional distress or poor mental health. Socioeconomically disadvantaged individuals are more likely to experience ongoing stress and negative life events, thus increasing their risk of suicidal behaviour.

- In the UK, socioeconomically disadvantaged individuals are less likely to seek help for mental health problems than the more affluent and are less likely to be referred to specialist mental health services following self-harm by GPs located in deprived areas.

(*Socioeconomic disadvantage and suicidal behaviour: Finding a way forward for Wales / Samaritans Cymru*)

**Children and Young People**

Suicide is the biggest killer of young people (15-24). In 2018, 759 young people took their own life in the UK and Republic of Ireland. Every single one of these deaths is a tragedy that devastates families, friends and communities.

Three quarters of deaths among young people are male, and rates are highest in men aged 20-24.

In Wales -

- Mental health problems affect 1 in 10 children and young people – around 3 children in every average-sized classroom

- People who have experience adverse childhood experiences (ACEs) are at much greater risk of mental illness throughout life. Based on a study by Public Health Wales and Bangor University, adults who had suffered four or more types of ACE were almost 10 times more likely to have felt suicidal or self-harmed than those who had experienced none. (*Sources of resilience and their moderating relationships with harms from adverse childhood experiences*, Public Health Wales / Bangor University 2018)

**Trends in suicide among young people in the UK**

In the UK, suicide rates increased for all groups of young people in 2018. (15-19 / 20-24 / 25-29) Suicide rates among men aged 20-24 had been decreasing, but this year there was a significant increase of 30%.

**Why do young people take their own life?**

Suicide is complex and is rarely caused by one thing. It usually follows a combination of adverse childhood experiences, stressors in early life and recent events. Research shows that bereavement, abuse, neglect, self-harm, mental or physical ill health, and experiencing

academic pressures are just some of the common risk factors for suicide among young people. Of course, though, most young people will experience these stresses and not go on to take their own lives.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: *Suicide by children and young people in England*, published the following findings –

- Academic pressures and bullying were found to be more common before suicide in young people under 20
- Workplace, housing and financial problems were more common for 20-24-year-olds
- Suicide-related internet use was found in 26% of deaths in under 20s and 13% of deaths in 20-24-year-olds
- Young people and self-harm

A major concern is the increase in self-harm among young people over the last 15 years. Self-harm is a sign of serious emotional distress and, while most people who self-harm will not go on to take their own life, it is a strong risk factor for future suicide. There are many definitions of self-harm. Researchers, clinicians, charities and media all often use the term to mean different things. Samaritans defines 'self-harm' as any deliberate act of self-poisoning or self-injury *without* suicidal intent. This excludes accidents, substance misuse and eating disorders. Self-harm is more common among young people than other age
groups6. Self-harm increased across all age groups between 2000 and 2014, but it increased the most among young women.

**Why do young people self-harm?**

Self-harm is often used as a way of trying to obtain relief from emotional distress or expressing feelings that are difficult to communicate. Evidence shows that people who self-harm may feel distress more intensely and be more likely to try and avoid negative thoughts and feelings, even when doing so may lead to more harm in the long run. In this way self-harm can become a repeated behaviour, used as a response to emotional distress. However, research shows that longer term self-harm is ineffective at managing emotional distress. And longer-term self-harm is associated with developing thoughts about suicide.

**Why is the increase in self-harm concerning?**

We still don't know enough about why self-harm is increasing among young people. The increase is concerning because it might lead to:

• self-harm becoming further normalised as a way to cope with emotional distress
• self-harm becoming a long-term response to emotional distress
• an increase in future suicides

## 3) Suicide prevention in Wales – What do we want to see?

To improve the reliability and availability of data we need more accurate and timely statistics across the UK and Republic of Ireland, and are calling for the following:

- **Review of the death registration process in Wales, England, Northern Ireland and the Republic of Ireland**

In Scotland the maximum time between a death and registration is eight days. In other countries, deaths are registered after an inquest, which means there can be delays of a year or more before a death is recorded and appears in suicide data. This makes it harder to pick up changes to suicide rates and respond quickly. We would like to see a process in line with Scotland (see page 22 of our *Suicide Statistics* 2019 report for further information).

- **National database of inquest and procurator fiscal findings**

In Wales, England, Northern Ireland and the Republic of Ireland, coroners conduct detailed inquests when someone dies unexpectedly, speaking to family members and friends to understand the life experiences affecting the person who died. But this information is kept locally in coroner records or within the Procurator Fiscal Service and only basic demographics such as sex, age and location are reported nationally. This makes it difficult to research risk factors systematically and hugely restricts our knowledge of suicide. A centralised electronic database would overcome this issue and dramatically improve our understanding of the risk factors associated with people who die by suicide.

- **The Welsh Government should set out a Wales Poverty Strategy**

Our previous work and report on socioeconomic disadvantage and suicidal behaviour, and school exclusion, highlights the ways in which growing up or living in poverty can have devastating consequences for individuals and communities. Poverty in Wales affects education, health, social mobility, child development and life expectancy. Most significantly, poverty can increase the risk of suicide.

Within this programme of work, we have called for a centralised strategy for poverty which promotes cross-governmental and cross sectoral involvement. We continue to believe this is imperative for such a major public health issue, which interacts with a complex range of co-existing factors including educational disadvantage and exclusion. We need a strategy which mitigates the impact of poverty on individuals and communities and sits alongside economic strategies.

Alongside this work, we have also recently published a report on the link between school exclusion and suicide risk. Exclusion is far more than the act of removing a child from school. Exclusion from school is linked to a much wider set of recurring inequalities, circumstances and consequences including suicide risk, poverty, loneliness and social isolation, Adverse Childhood Experiences (ACEs) and the criminal justice system. Its impact on the life chances of young people can be far reaching.

In terms of school exclusion specifically, a poverty strategy of this kind could work to implement a preventative approach to reducing high rates amongst those pupils who are most deprived who continue to account for a high percentage of the cohort.

- **Mental health education should be statutory in the new curriculum**

We must embed a public health approach to poor mental health and adversity experienced by children and young people by placing a primary focus on prevention rather than cure alone. Investment in prevention and early intervention can reduce human, social and economic costs.

Since the Donaldson review in 2015, we have continued to call for statutory mental health education in schools. Emotional health programmes in schools should be viewed as a form of promotion, prevention and early intervention which could reduce pressure on CAMHS, reduce specific mental health problems, increase academic achievement and reduce exclusion. We believe that mental health education should be awarded the same statutory status as Sex and Relationship Education (SRE).

Mental health education could enable children and young people better to understand their emotions and emotional distress and develop coping strategies. Crucially, it can enable them to know when they need to ask for help. We must provide pupils with the tools they need better to manage their own mental health where possible.

We believe that much of the content and ambitions of the four purposes is linked to children and young people having good mental health or having the ability to recognise when their mental health is suffering and crucially, having the knowledge of how they can cope and where they can turn for help.

Due to our concerns surrounding the inclusion of mental health education, and most prominently, it's lack of statutory status, we are currently unable to judge the level at which the four purposes could be fulfilled.  It's crucial we work to address this, particularly over the next few months.