**Manchester City Council**
**Report for Resolution**

**Report to:** Health Scrutiny Committee – 12 March 2015

**Subject:** Prevention of Suicide in Manchester

**Report of:** Director of Public Health

---

**Summary**

This report provides the Committee with an update on the paper submitted in January 2014 and on progress in response to the national strategy 'Preventing Suicide in England' published in September 2012.

**Recommendations**

The Committee is asked to:

I. Note the report.

II. Consider the multiple factors that impact upon suicide rates including the evidence of the impact of mental ill-health, economic and social factors.

---

**Wards Affected:** All

---

**Contact Officers:**

Name: David Regan
Position: Director of Public Health
Telephone: 0161 234 3981
E-mail: d.regan@manchester.gov.uk

Name: Janet Mantle
Position: Consultant in Public Health
Telephone: 0161 234 3600
E-mail: j.mantle@manchester.gov.uk

We would like to acknowledge input to this paper from Professor Nav Kapur (University of Manchester), Douglas Inchbold (Manchester Health and Wellbeing Service) Christine Raiswell (MCC) and Neil Bendel (MCC)
Appendix 2 Network Rail case study supplied by Katie Panteli –Suicide Prevention Lead

**Background documents (available for public inspection)**

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above

National Mental Health Strategy: 'No Health without Mental Health' 2011
The National Strategy 'Preventing Suicide in England: a cross government outcomes strategy to save lives' September 2012
Both documents are available on www.dh.gov.uk/publications

Prevention of Suicide in Manchester. Report to Health Scrutiny Committee. January 2013
Report on Self Harm presented to Health Scrutiny Committee. November 2013 (see appendix)

## 1. Introduction

1.1 Every suicide is both an individual tragedy and a loss to society. Every suicide affects a number of people directly and indirectly and can have a devastating effect emotionally, spiritually and economically. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

1.2 The aim of this paper is to refresh the overview of what is known about suicide, including factors that impact on levels of suicide, identification of those who may be at higher risk and the evidence for effective prevention.

1.3 In September 2012 the national suicide prevention strategy was published (see above). Significantly, the national strategy identifies Health and Wellbeing Boards as having the lead responsibility for local suicide prevention. This paper reflects the content of the strategy and provides an update on the focus of the local response and achievements since the committee discussed this issue in January 2014.

## 2. What we know about Suicide

2.1 The focus of the 2012 national strategy includes measures to support families/loved ones, communities and colleagues affected by suicide. The annual progress report published in 2014[1] acknowledges the impact that the economic downturn has had on increases in suicide nationally and the need to ensure that all levels of service, including primary care, are equipped to identify and support those at risk.

2.2 The likelihood of someone taking their own life depends on several factors. Statistically, a number of groups are known to be at higher risk than the general population, these include:

- Gender – males are three times as likely to take their own life as females (particularly adult men under 50)
- Age – people aged 40-49 now have the highest suicide rate
- People in the care of mental health services (though the majority of people who die by suicide – around 75% - are not known to mental health services)
- People with a history of self harm[2]
- People with untreated depression
- People who are especially vulnerable due to social and economic circumstances
- Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
- Survivors of abuse or violence, including sexual abuse
- Veterans

[1] Preventing Suicide:one year on. Department of Health. January 2014
[2] See paper on self harm submitted to scrutiny in November 2013

- People with physically disabling or painful illnesses including chronic pain and long term conditions
- People who misuse alcohol and/or drugs
- Lesbian, gay, bisexual and transgender people
- Black, Asian and minority ethnic groups and asylum seekers
- Specific occupational groups such as doctors, nurses, veterinary and agricultural workers

2.4 There is also evidence that stressful life events can play a part either singly or in combination. These include:

- The loss of a job / unemployment
- Imprisonment
- Debt
- Living alone, social isolation or discrimination / bullying
- Bereavement
- Family conflict or breakdown, divorce and family mental health problems

2.5 A report by the Scottish Government Social Research department conducted in 2008 reviewed the social and cultural factors that are associated with an increase in suicides and also identified the factors that promote resilience[3]. This report and the national strategy on preventing suicide in England both emphasise that suicides are not inevitable and that an inclusive society that supports people at times of personal and economic crisis will help to prevent suicides.

2.6 There are a number of evidence based activities to prevent suicide. These include taking specific steps to reduce risk for those in the care of mental health and criminal justice services, for example, by reducing access to the means to take their own lives. Identifying population groups at potential risk and building resilience and support is also important and this would include people who are survivors of childhood violence and abuse; groups facing discrimination such as lesbian and gay and black and minority ethnic communities.

2.7 There is also evidence that raising awareness and improving the skills of frontline professionals and members of the public to support people at risk of suicide is a key protective factor.

2.8 As Manchester is the fourth most deprived area in England with high levels of chronic illness and poverty, based on the risk factors identified, there is potentially a large population of individuals at risk of suicide. The recent economic crisis and associated job losses and ongoing reduction in public sector services may also have an impact. Recent research has demonstrated the link between percentage point increases in unemployment and increases

[3] Risk and protective Factors for Suicide and Suicidal Behaviour. www.scotland.gov.uk/publications/2008/11/2814144/23

in suicide and alcohol consumption on an international level and with specific reference to England[4] [5]

## 3 Levels of Suicide in Manchester

3.1 Since the last update for the Committee in January 2014, the definition of mortality (death) from suicide and injury undetermined has been revised. The Office for National Statistics (ONS) definition of suicide includes deaths given an underlying cause of *intentional self harm* or an injury/poisoning of *undetermined intent*. For adults and older children, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves.

3.2 However, the same cannot be assumed for deaths of children under 15 due to the possibility that these deaths were caused by unverifiable accidents, neglect or abuse. For this reason, the new official definition of suicide and injury undetermined only includes deaths of undetermined intent in adults aged 15 years and over.

3.3 The mortality rates presented in this paper also differ from the ones included in the last update to the Committee because of changes to the methodology used by ONS, specifically the use of the revised 2013 European Standard Population and a change in the coding rules used to identify the underlying cause of death.

3.2 The three-year average mortality rate from intentional self-harm and undetermined injury (i.e. suicide) in Manchester has fallen from 15.9 deaths per 100,000 population in 2001-03 to 11.8 deaths per 100,000 population in 2011-13. This represents a reduction of 25.7% since the beginning of the last decade. Due to changes in the definition of suicide described above, it is no longer possible to assess progress in respect of the former Our Healthier Nation target of a 20% reduction in suicide rates by 2010.

3.3 The absolute gap in the rate of suicide and undetermined injury between Manchester and England has reduced from a gap of 5.4 deaths per 100,000 population in 2001-03 to 3.1 deaths per 100,000 population in 2011-13 This is equivalent to a reduction in the gap of 43.6% over the period. The relative gap in mortality rates between Manchester and England has also reduced over the same period, from 51.4% in 2001-03 to 34.8% in 2011-13.

3.3.1 Suicide rates are measured on a 3 year rolling average but this can mask changes that occur on a year by year basis. The following table shows the total number of suicides that have been registered each year since 2008. Although the number of suicides among Manchester residents increased

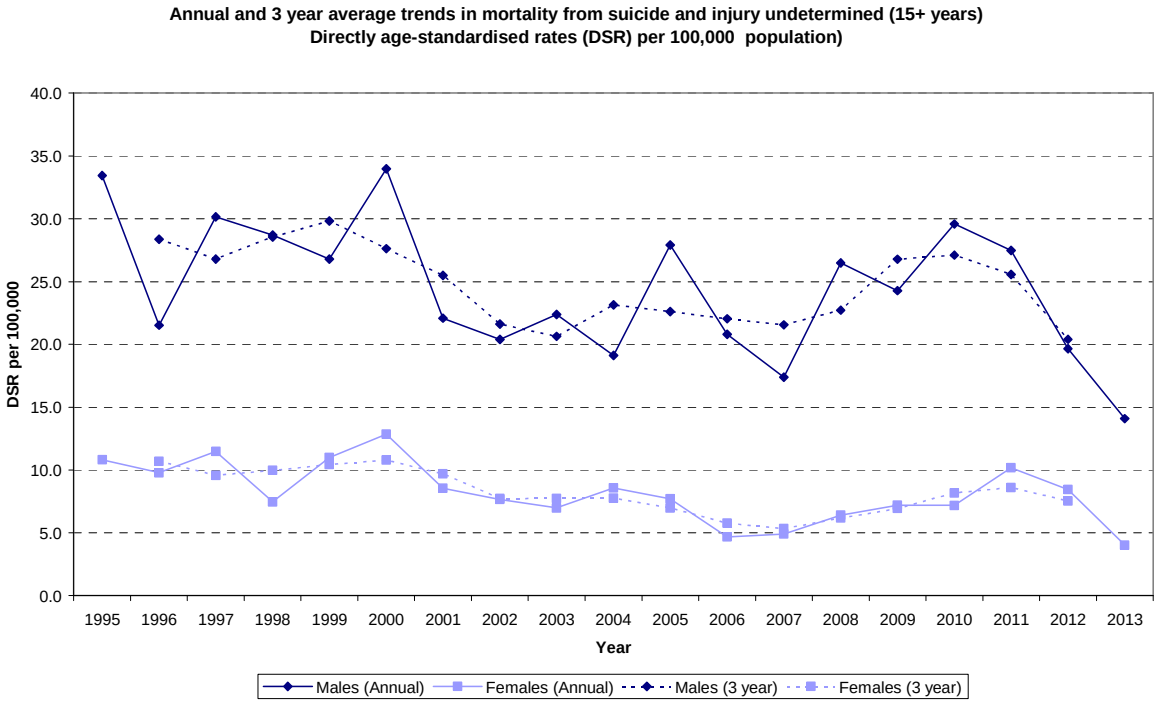
[4] Stuckler et al. What is the evidence of the impact of the economic crisis on public health? Oxford 2009.
[5] Barr B. et al Suicides associated with the 2008-10 economic recession in England: time trend analysis. BMJ 2012. 14 August

between 2008 and 2010, there has since been a reduction in the numbers, which is consistent with the long term trends.

| Year | Number of suicides (all ages) and injuries of undetermined intent (15+ only) | | |
|---|---|---|---|
| | Persons | Male | Female |
| 2008 | 54 | 44 | 10 |
| 2009 | 59 | 45 | 14 |
| 2010 | 66 | 55 | 11 |
| 2011 | 65 | 48 | 17 |
| 2012 | 53 | 38 | 15 |
| 2013 | 38 | 30 | 8 |

Current Trends and Progress towards Target

3.3.2 The table below provides a representation of recent trends on an annual basis and by three year rolling average. Both methods identify a downward trend but the rolling average may be more accurate in accounting for annual variations in relatively small numbers.




3.3.3 An analysis of suicide deaths in Manchester conducted by Manchester University 1997-2012[6] indicates an overall median age of 40 at time of suicide and that 76% of suicides occur in men. Of those in touch with mental health services (approximately 27% of the total) there are some common demographic features with over 52% living alone, 49% unemployed and 83% not currently married. Of this group 72% have a history of self harm and 60%

[6] Dr Isabelle Hunt and Professor Nav Kapur, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Manchester Self Harm project.

have a history of alcohol abuse. Whilst we are seeing a significant fall in the general population suicide rate there is no similar trend in the patient rate, which remains more consistent[7].

3.3.4 It is difficult to identify why we are seeing a fall in suicide rates. A number of factors may be having an impact including the slowing down of the recession. A paper presented to the Health Scrutiny Committee in November 2014 referenced the NW Mental Wellbeing Survey 2012-3 which indicated that there had been an overall improvement in wellbeing in the city, however other less favourable factors such as reduced social connectivity were also indicated[8].

3.4 Young People and Suicide

3.4.1 The 2012 national strategy identifies specific categories of young people as being at higher risk of suicide. This include those who fall into the general risk categories identified and especially looked after children, care leavers and children and young people in the Youth Justice System.

3.4.2 The current ONS data does not capture deaths of undetermined intent in people under 15. Further discussion is needed about how we capture data relevant to under 15 year olds.

## 4. Greater Manchester and Manchester Plans to Prevent Suicide

4.1 The Greater Manchester Public Health Network has established a suicide prevention work stream. The initial strategy expired in 2013 and there has been a programme review. The new arrangements include the establishment of an executive group who will collate information on a Greater Manchester basis and a wider multi-agency reference group that will meet twice a year. A revised work programme is in development.

4.2 In Manchester, the Mental Health and Social Care Trust (MHSCT) convene a bi-monthly suicide prevention working group chaired by Professor Nav Kapur from the Centre for Suicide Prevention (University of Manchester), which has supported local projects including the Manchester Self-Harm project which has been running for the past 16 years, with many local and national outputs[9].

4.3 The above group continues to encompass discussion about suicide prevention in the clinical context and also joint prevention initiatives including:

- Co-ordination of local data and intelligence about suicide to inform planning and delivery of interventions
- Linking into the Greater Manchester network.

[7] See appendix 1
[8] McHale P & Hughes K. Mental Wellbeing in Manchester. The NW Mental Wellbeing Survey 2012-3. Centre for Public health JMU.
[9] http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/mash/RS/mashreport.pdf

- increase early identification of people at risk and enhance responses from professionals, families and local communities
- Increase understanding of mental health and suicide risk amongst front line staff in all organisations in contact with the public and amongst employers.
- Provide training in identification and response to suicide risk amongst staff in key organisations.
- Promote increased public understanding of suicide risk and reduce the stigma associated with talking about suicidal feelings.
- Promote/publicise sources of help and support for people experiencing suicidal feelings.
- Consideration of friends and family of those at risk for 'gatekeeper training', i.e. how to identify those at risk and support and refer them for treatment.
- Identify particularly vulnerable population groups and plan useful interventions
- Use of intelligence (above) to identify and prioritise vulnerable groups and, where possible, to identify local variation from or confirmation of those groups identified in the national strategy
- Work with people from priority populations, and those who represent them, to identify effective interventions.
- Identify "hotspot" locations for suicide and provide notices of help and support (in conjunction with Greater Manchester)
- Consider the contribution of wider public mental health activity in preventing suicides
- Review the evidence for commissioning wider public mental health activity in terms of potential to reduce suicides.

4.4 Manchester City Council (Children and Families Directorate) invests in a range of local mental health support via the community and voluntary sector. The MCC Public Mental Health investments support the aims of the Manchester Health and Wellbeing Strategy - Mental Health and Wellbeing (priority 6) to improve access to training for frontline staff, access to courses for the public, improved care planning for people with mental ill health and improved access to information and resources.

## 5 Examples of Local Achievements since January 2013

5.1 Improved access to information and training on mental health issues for professionals and the public (including at risk populations).

*Mental Health Training for Professionals*

- The Connect 5 training programme commissioned from Manchester Health and Wellbeing Service includes training on the importance of recognising and responding to suicidal thoughts during conversations with vulnerable people. Most organisations in receipt of training are in contact with people from vulnerable groups. There were 870 attendances by frontline staff between April 2013 and March 2014 and a further 463 between April and September 2014. The course continues to be in high demand.
- Safeguarding training offered by the Children and Families Directorate will alert staff to risk.

- Public Health (MCC) has commissioned a pilot programme of self-care training in North Manchester to support staff delivering integrated care under the Living Longer Living Better programme. People coping with long term illness can be at high risk of mental health problems and higher suicide risk and this programme will support staff to address emotional health needs. Over 280 frontline staff across health and social care have been trained in the pilot phase which started in October 2014. The Living Longer Living Better strategic group has now identified self care as one of the key objectives underpinning integrated care in the City.

As most people who commit suicide are not in touch with specialist mental health services[10], increasing confidence to respond amongst the wide range of front line staff is an important tactic in prevention. In Manchester the average percentage of the total number of people completing suicides in contact with mental health services is 27%.

*Training and Information for the Public*

- A range of educational courses, e.g. "Boost", about how to maintain good mental health and build "emotional resilience" are available to the public and many target people in vulnerable population groups, e.g. people with long term health conditions and those managing pain, carers, victims of domestic violence, troubled families and people with depression. Courses are often delivered in partnership between statuary and voluntary sector organisations in a growing collaboration via a network co-ordinated by the Manchester Health and Wellbeing Service. Substantial additional funding has been invested in this programme in 2014-2015. In order to reach a wider range of the population, course materials have been developed for flexible delivery, e.g. single session workshops.
- The distribution of self help information and publications provides appropriate, evidence based guidance for people in distress. This includes publications on how to manage suicidal thoughts, depression and anxiety and bereavement. Between April 2013 and March 2014, 33,141 mental health self help guides and information leaflets were distributed: of 32 different titles, with 3 new guides published during the year. A further 27,386 were distributed between April and September 2014.
- The Mental Health in Manchester website provides a guide to better mental health and getting help, including emergency contacts and phone lines www.mhim.org.uk . This site receives an average of 4000 visits a quarter and over 75% of these are new visits. Just under a half of these are by Manchester people.
- Guidance published for staff in Health and Wellbeing services who may find themselves in conversation with people who express thoughts of suicide.
- An information stall was held for Manchester City Council staff and members of the public as part of 'Time to Talk' day on 5th February – a

[10] Dr Isabelle Hunt and Professor Nav Kapur, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. See appendix 1

campaign to reduce stigma and discrimination related to mental health problems by encouraging people to have conversations with friends, family and colleagues about their mental health.

- Activities to raise awareness of self harm / self injury will be delivered as part of Self Injury Awareness Day on 1st March 2015 including an information road-show at local markets, a twitter question and answer session, a joint press release between MHSCT and MCC and a newly developed resource to support people to keep safe, seek help or help others at risk of self harming.

5.2 The Manchester Mental Health and Social Care Trust Suicide Prevention strategy (launched 2013). The focus of this strategy is on specialist mental health services; however, longer term the aim is to integrate this as part of a wider strategy for the City. Allied to these initiatives is work being carried out as part of the Manchester Academic Health Sciences Centre (MAHSC) safety theme auditing services, identifying risk assessment instruments, and providing training to emergency department and general hospital staff.

5.3 The Manchester Health and Wellbeing Strategy (MHWBS) was produced in 2013 and includes mental health and wellbeing, including suicide prevention, as one of the eight priority areas for action.

5.4 We have developed a performance and evaluation framework linked to the priorities of the MHWBS strategy to monitor the impact of the strategy on mental wellbeing, better understand the contribution of different agencies and promote the importance of investment in mental health and wellbeing to a wider audience. An initial annual report was produced in March 2014.

5.5 The findings of the Government's All- Party Parliamentary Group (APPG) on local suicide prevention plans in England were published in January 2015. Manchester scored well on two out of the three core criteria i.e. having a suicide prevention plan and a suicide prevention group in place. The third requirement relates to conducting a local suicide audit on an annual basis. Public Health in Manchester has not done this recently as the evidence is that conducting these audits on a broader geographical area is more useful. This will be discussed at a Greater Manchester level.

5.6 Other organisations are taking positive steps. Network Rail, working in partnership with Samaritans, is taking a proactive approach to reducing suicides on the railway and supporting staff that may be affected by it. (see case study appendix 2 )

## 6. Recommendations

6.1 The committee is asked to:

- Note the report
- Note and comment on progress made since January 2014
- Consider the multiple factors that impact on suicide including mental ill health, economic and social factors

**Appendix 1**

**Suicide deaths in Manchester 1997-2012**

**6th February 2015**

**Summary**

- Suicide rates in the general population in Manchester appear to have fallen between 1997 and 2012 (table 1 and Figure1) but they remain amongst the highest in the North West (Figure 2).
- The proportion of people in contact with services before suicide has varied over this time period, but the average proportion in contact is similar to national figures.
- We are working on producing figures that express the rate of suicide per number of people seen by mental health services or number of mental health service contacts.
- The characteristics of Manchester residents who died by suicide are somewhat different to the characteristics of those who die by suicide in England as a whole. For example, Manchester residents have higher rates of death by self-poisoning; they are more often on long-term sick leave or from a black and minority ethnic group; and they are more likely to have a history of drug misuse, alcohol misuse and violence. This is probably a reflection of differences in the socio-demographic characteristics of the underlying population as well as possible specific risk factors for suicide.
- All data are based on individuals with postcodes in the City of Manchester.
- Because the numbers are relatively small, trends will inevitably be influenced by random fluctuations.

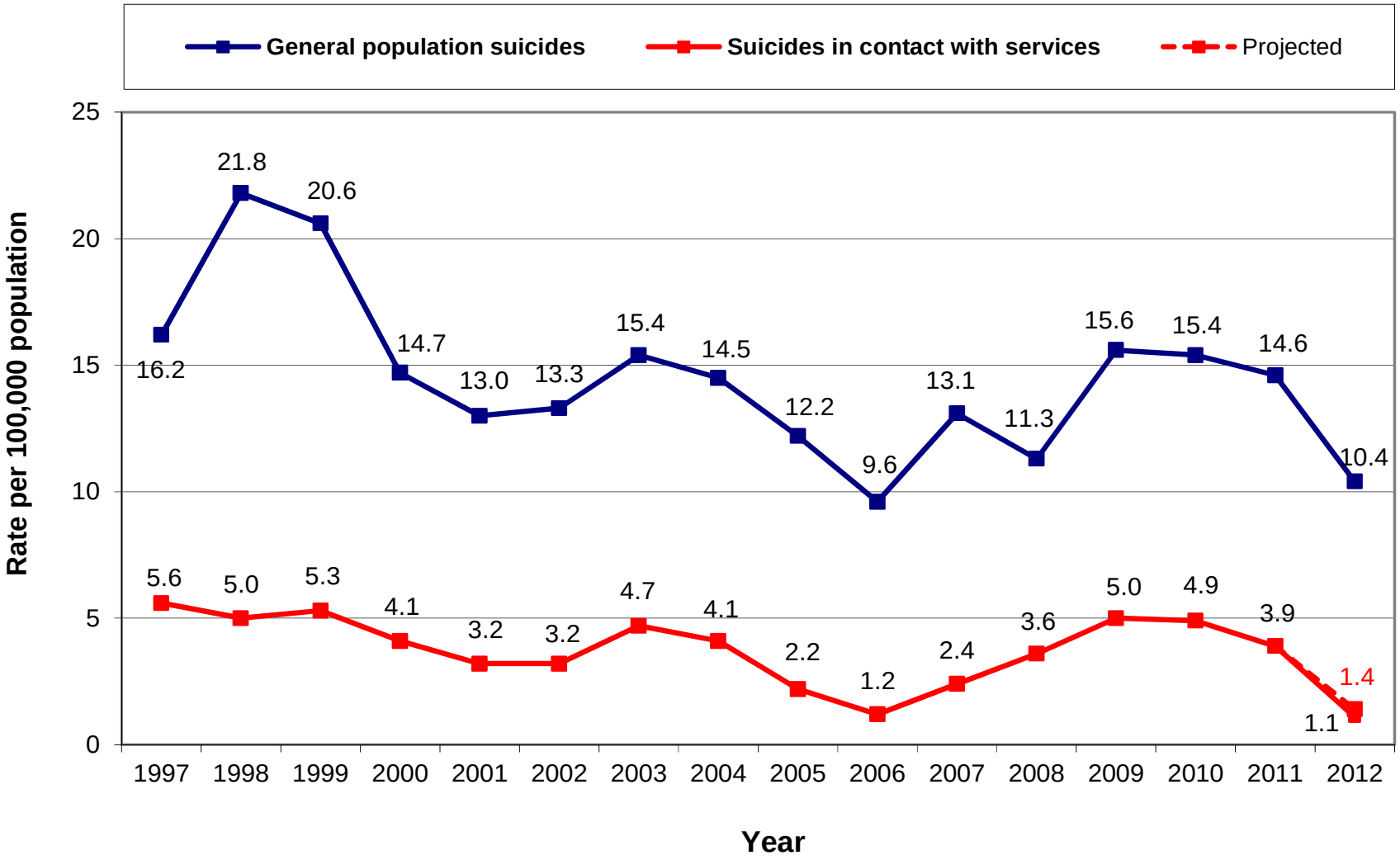
(Source: National Confidential Inquiry and ONS)

**Table 1: Suicide deaths in Manchester (1997-2012)**

| | General population suicides N=909<br>N | Contact within 12 months[A] N=234<br>N | % in contact[B] (26% average) | % England in contact[B] (27% average) |
|---|---|---|---|---|
| **1997** | 58 | 20 | 34% | 24% |
| **1998** | 78 | 18 | 23% | 24% |
| **1999** | 74 | 19 | 26% | 25% |
| **2000** | 54 | 15 | 28% | 26% |
| **2001** | 48 | 12 | 25% | 27% |
| **2002** | 50 | 12 | 24% | 27% |
| **2003** | 59 | 18 | 31% | 27% |
| **2004** | 57 | 16 | 28% | 28% |
| **2005** | 49 | 9 | 18% | 29% |
| **2006** | 39 | 5 | 13% | 27% |
| **2007** | 54 | 10 | 19% | 27% |
| **2008** | 47 | 15 | 32% | 26% |
| **2009** | 66 | 21 | 32% | 27% |
| **2010** | 66 | 21 | 32% | 28% |
| **2011** | 64 | 17 | 27% | 29% |
| **2012** | 46 | 6 | 13% | 28% |

[A] Individuals who died by suicide within 12 months of mental health service contact; [B] '% in contact' refers to the proportion of general population suicide deaths which occurred in individuals within 12 months of mental health service contact.

**Figure 1: Rates of suicide per 100,000 population in Manchester**




Note: Significant fall between 1997-2011 in the general population rate; no significant trend in the patient rate

**Figure 2: Standardised suicide rates in the North West (average rate 2011-13, based on year of registration)**

England

**4.10 - Suicide rate (Persons)** 2011 - 13

Directly standardised rate - per 100,000

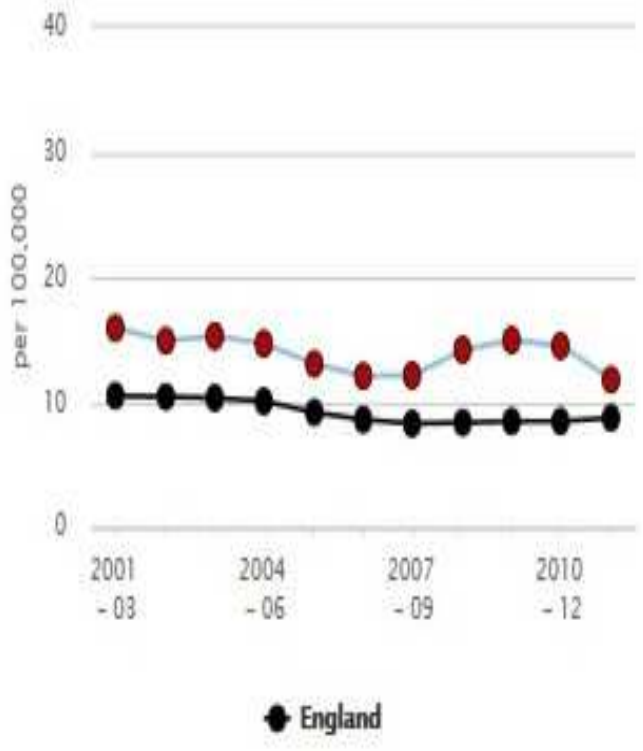
| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|
| **England** | 13,758 | 8.8 | 8.6 | 8.9 |
| North West | 2,095 | 10.1 | 9.7 | 10.5 |
| Blackpool | 55 | 13.6 | 10.2 | 17.7 |
| Blackburn with Darwen | 50 | 12.0 | 8.9 | 15.9 |
| St. Helens | 62 | 11.9 | 9.1 | 15.3 |
| Manchester | 156 | 11.8 | 9.9 | 14.0 |
| Bolton | 93 | 11.5 | 9.3 | 14.1 |
| Stockport | 94 | 11.4 | 9.2 | 14.0 |
| Wigan | 108 | 11.3 | 9.3 | 13.7 |
| Knowsley | 47 | 11.1 | 8.1 | 14.8 |
| Cumbria | 162 | 10.9 | 9.3 | 12.7 |
| Lancashire | 354 | 10.2 | 9.2 | 11.4 |
| Tameside | 65 | 10.2 | 7.8 | 13.0 |
| Oldham | 64 | 10.0 | 7.7 | 12.7 |
| Rochdale | 61 | 9.9 | 7.6 | 12.8 |
| Bury | 53 | 9.8 | 7.4 | 12.9 |
| Sefton | 81 | 9.7 | 7.7 | 12.1 |
| Halton | 36 | 9.6 | 6.7 | 13.3 |
| Liverpool | 127 | 9.5 | 7.9 | 11.3 |
| Warrington | 55 | 9.2 | 7.0 | 12.0 |
| Trafford | 60 | 9.2 | 7.0 | 11.9 |
| Salford | 63 | 9.2 | 7.0 | 11.8 |
| Cheshire West and Chester | 88 | 8.9 | 7.2 | 11.0 |
| Wirral | 74 | 8.0 | 6.3 | 10.1 |
| Cheshire East | 87 | 7.9 | 6.3 | 9.8 |

*Source: Public Health England (based on ONS source data)*

**Figure 3: Public Health England suicide rates in Manchester 2001-2013**

## 4.10 - Suicide rate (Persons) Manchester

Directly standardised rate - per 100,000




| Period | Sig | Count | Value | Lower CI | Upper CI | North West | England |
|---|---|---|---|---|---|---|---|
| 2001 - 03 | ● | 191 | 15.9 | 13.6 | 18.5 | 11.8 | 10.5 |
| 2002 - 04 | ● | 177 | 14.9 | 12.7 | 17.4 | 11.4 | 10.5 |
| 2003 - 05 | ● | 190 | 15.3 | 13.1 | 17.8 | 11.5 | 10.4 |
| 2004 - 06 | ● | 184 | 14.7 | 12.5 | 17.1 | 11.3 | 10.1 |
| 2005 - 07 | ● | 168 | 13.1 | 11.0 | 15.4 | 10.6 | 9.2 |
| 2006 - 08 | ● | 147 | 12.1 | 10.1 | 14.4 | 9.7 | 8.6 |
| 2007 - 09 | ● | 153 | 12.2 | 10.2 | 14.4 | 9.5 | 8.3 |
| 2008 - 10 | ● | 179 | 14.2 | 12.1 | 16.6 | 9.4 | 8.4 |
| 2009 - 11 | ● | 191 | 15.0 | 12.8 | 17.4 | 9.7 | 8.5 |
| 2010 - 12 | ● | 185 | 14.5 | 12.3 | 16.9 | 9.6 | 8.5 |
| 2011 - 13 | ● | 156 | 11.8 | 9.9 | 14.0 | 10.1 | 8.8 |

*Source: Public Health England (based on ONS source data)*

**Table 2: General population suicides in Manchester (1997-2012)**

| | **Manchester suicides N=909** | | **Remaining England suicide sample N=73,106** | |
|---|---|---|---|---|
| | **N** | **%** | **N** | **%** |
| **Age and sex** | | | | |
| Age: median (range) | 40 (13-96) | | 44 (10-104) ** | |
| Male | 694 | 76% | 54,979 | 75% |
| **Method** | | | | |
| Hanging | 356 | 39% | 30,369 | 42% |
| Self-poisoning | 314 | 35% | 17,481 | 24% ** |
| Jumping /multiple injuries | 79 | 9% | 7,252 | 10% |
| Carbon monoxide poisoning | 22 | 2% | 4,298 | 6% ** |
| Drowning | 30 | 3% | 3,599 | 5% * |
| Other† | 101 | 11% | 9,481 | 13% |
| Unknown/unascertainable | 7 | 1% | 626 | 1% |

** p<0.001 * p<0.05
†includes firearms, suffocation, electrocution, burning, cutting & other specified

**Table 3: Suicides in contact with mental health services in the 12 months before death in Manchester (1997-2012)**

| | Manchester suicides N=233 | | Remaining England suicide sample N=19,362 | |
|---|---|---|---|---|
| | N | valid % | N | valid % |
| **Demographic features** | | | | |
| Age: median (range) | 41 (16-95) | | 44 (10-98) ** | |
| Male | 168 | 72% | 12,820 | 66% |
| Not currently married | 187 | 83% | 13,301 | 70% ** |
| Living alone | 116 | 52% | 8,453 | 45% |
| Unemployed | 111 | 49% | 7,850 | 42% * |
| Long-term sick | 58 | 26% | 3,005 | 16% ** |
| Black and minority ethnic group | 29 | 13% | 1,400 | 7% * |
| **Method** | | | | |
| Self-poisoning | 104 | 45% | 5,254 | 27% ** |
| Hanging/strangulation | 73 | 32% | 7,486 | 39% * |
| Jumping/multiple injuries | 23 | 10% | 2,924 | 15% * |
| Other[†] | 31 | 13% | 3,604 | 19% * |
| **Priority groups** | | | | |
| In-patient | 19 | 8% | 2,309 | 12% |
| Post-discharge patients | 32 | 15% | 3,702 | 22% * |
| Missed last appointment | 60 | 30% | 4,514 | 27% |
| Non-compliant with medication in last month | 43 | 22% | 2,739 | 16%* |
| **Clinical features** | | | | |
| Primary diagnosis: | | | | |
| Schizophrenia | 60 | 26% | 3,431 | 18% * |
| Affective disorder | 86 | 37% | 8,745 | 46% * |
| Alcohol dependence | 30 | 13% | 1,614 | 8% * |
| Drug dependence | 20 | 9% | 798 | 4% * |

| | | | | |
|---|---|---|---|---|
| Personality disorder | 12 | 5% | 1,746 | 9% * |
| Other primary diagnosis‡ | 24 | 10% | 2,413 | 13% |
| Any secondary diagnosis | 130 | 56% | 9,980 | 52% |
| Duration of mental illness (under 12 months) | 26 | 11% | 3,875 | 21% * |
| **Behavioural features** | | | | |
| History of self-harm | 160 | 72% | 12,806 | 68% |
| History of alcohol misuse | 134 | 60% | 8,249 | 44% ** |
| History of drug misuse | 103 | 46% | 5,791 | 31% ** |
| History of violence | 59 | 27% | 3,958 | 21% * |
| **Contact with services** | | | | |
| Last contact within 7 days of death | 93 | 41% | 9,439 | 49% * |
| Symptoms at last contact | 150 | 69% | 11,849 | 64% |
| Estimate of immediate risk: low or none | 164 | 85% | 15,422 | 86% |
| Estimate of long-term risk: low or none | 85 | 53% | 9,294 | 59% |

** p<0.001 * p<0.05

† includes CO poisoning, drowning, firearms, cutting, suffocation, burning, electrocution & other specified

‡ includes anxiety disorders, eating disorder, adjustment disorders, dementia, organic disorder, conduct disorders, learning disability and other specified.

## Provisional: Rates of self-harm in Manchester 2003-2012

**6th February 2015**

Rates of self-harm presenting to hospitals in Manchester appear to have increased since 2008. The increase has been particularly pronounced in men, with the largest increases in men aged 35-54, but rates have also increased in young women (source: MaSH Project)

**Figure 1: Rates of self-harm by sex 2003 to 2012**

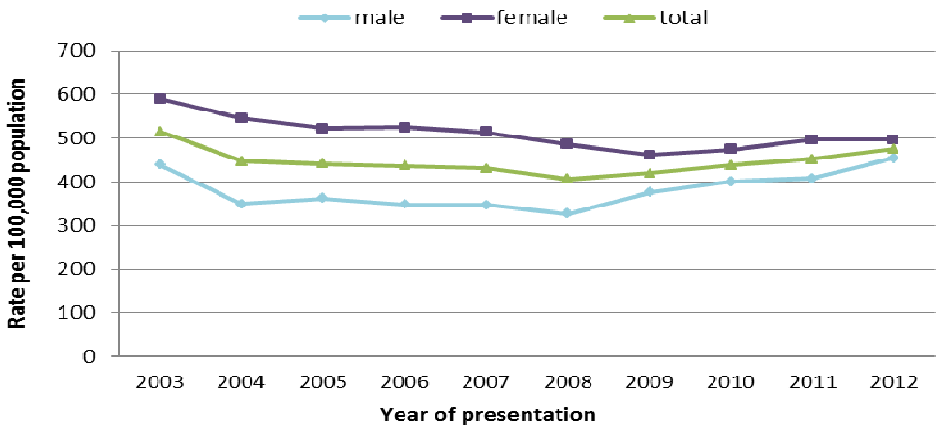



**Figure 2: Rates of self-harm among males, by age group, 2003-2012**

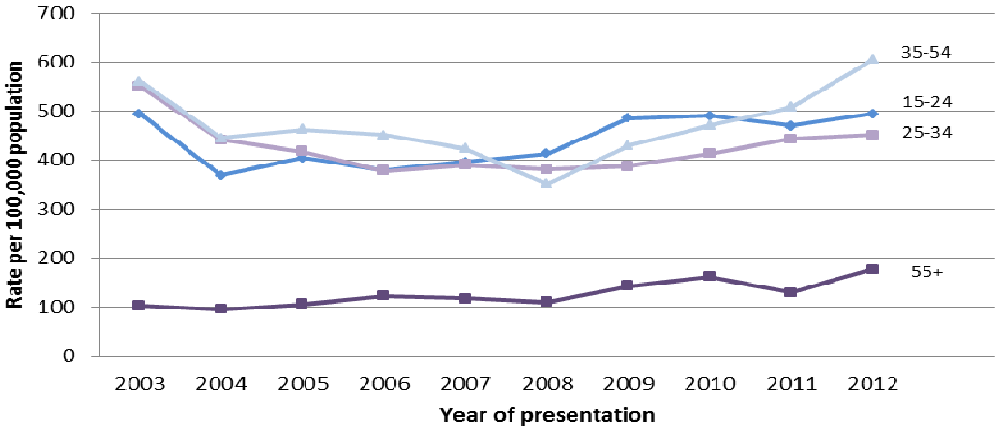
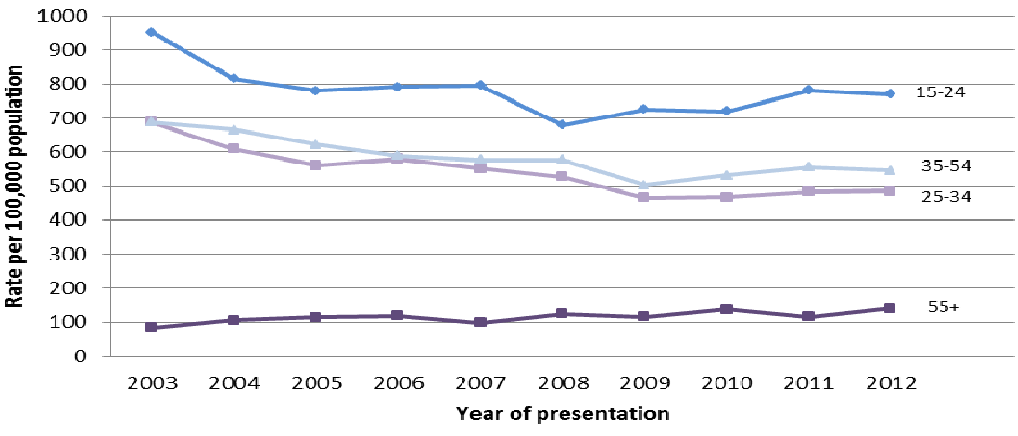



**Figure 3: Rates of self-harm among females, by age group, 2003-2012**



**Appendix 2**
**Overview of Network Rail's Suicide Prevention Programme**

Suicides on Britain's railways account for around 4% of national suicides every year. This causes Network Rail a considerable amount of financial loss, not to mention the human impact of an incident. For example, one incident could cost Network Rail £700k and have a significant impact on 50,000 people. The people who are impacted range from the train driver and the families of the deceased, to people suffering delays to their journeys.
In 2009, Network Rail agreed a five-year partnership with the Samaritans which had the objective of reducing suicides on the railway. This partnership was renewed for another five years at the end of 2014. In addition to our partnership with the Samaritans, we also work closely with the British Transport Police.

In the past Network Rail has taken a reactive approach to suicide prevention, however, we are now utilising a more intelligence led approach which involves the use of British Transport Police data to identify potential hotspot locations.

**Who takes their lives on the railway?**

Network Rail's research has shown that 80% of people who take their lives on the railway are white males aged between 30 and 55. As a result of this research we have been able to target the Network Rail/Samaritans campaign to this demographic. The research has also suggested that 74% of people who have died by suicide on the railway have suffered from mental health problems (36% diagnosed, 38% undiagnosed).

**Where do suicides on the railway take place?**

Nationally, around 40% of incidents occur at stations, with 60% taking place at line side locations. However, in the North West, around 60% of incidents occur at stations and 40% at line side locations.
We have also found that there are links between railway suicides and areas of social deprivation.

**The Cornerstones of the Programme**

- Hotspot identification
- Social deprivation mapping
- Media management
- Samaritans training courses made available to all railway personnel with over 6,000 members of staff having attended so far – these training courses centre around identifying vulnerable people and giving staff the confidence to approach such people and get them to a position of safety
- Campaign communications material
- Samaritans volunteers
- Dedicated Suicide Prevention Hotline run by the British Transport Police

**How do we further the programme?**

- Smart camera technology
- Deploying engineering solutions
- Mitigation measures – for example, yellow hash markings on the platforms to demarcate where passengers should and should not be standing
- We will continue to promote our partnership with the Samaritans
- We have National Suicide Prevention Working and Steering Groups
- Creating links within the community to further our community outreach goals
- Community Outreach programmes

**Manchester City Council Area**

There are 15 train stations within the City of Manchester. Since 2012 there have been no fatal incidents. This goes against the national trend, which has seen railway suicides increase in the last two years.

There have been a number of reasons why we have had no railway suicides in Manchester:

- Northern Rail have been incredibly engaged with the programme and this participation has seen a considerable number of their station staff trained on the Samaritans Managing Suicidal contacts course
- A number of the above stations now have platform end fencing, which prevents access to the tracks from the ends of the platforms
- Deployment of Samaritans material at all the stations that have had fatal incidents
- All staffed stations have also received Samaritans tactics cards, which is a condensed version of the Managing Suicidal contacts course. The stations also have Samaritans business cards for potentially vulnerable people

**Greater Manchester Area**

It may also be useful to have some information on what we are doing in the rest of the Greater Manchester area. For example, we have recently seen an increase at Stockport Station and Viaduct. The period between September and December 2014 saw 11 incidents of suicidal people on the station and viaduct. As a result we have focused a lot of effort on deploying engineering solutions to prevent access to the railway at the station and in the surrounding area. We have also been working closely with the media through the Samaritans press office to ensure appropriate reporting of incidents, and we had engagement with Stockport Council's Public Health representative.