Help-seeking and service contacts among suicides in Northern Ireland:

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Overview

- Context
- Help-seeking, mental health and suicide
- Understanding Suicide study
- Health Service Contacts of suicide cohort
- Exploration of service failure (families & General practitioners)
- Conclusions & Recommendations

Urban rural differences in suicide and help-seeking

- Anomie: Suicide as an urban phenomenon (Durkheim)
- Trend towards increased suicide rates in rural areas? (Hirsch,2007)
- Increases in rural suicide among young people in Australia (1979-2003).
- Slight raised suicide risk for English males & Welsh females (2003-2004)

Help seeking factors

Socio-demographic:
Age, gender, education, employment and occupation, marital status, isolation, ethnicity

Structural:
Economic,
political,
Legal

Personal:
Symptom recognition, severity, ability to function, disruption, visibility,

Community and family tolerance and support,

Service-related:
Organisation, provision, access, acceptability, policies, workforce, Professional recognition, Knowledge and training, technology.

Cultural:
Religion, belief systems, explanatory models of MI, knowledge, stigma,

Help-seeking prior to suicide

- 77% (range 55-80%) of people contact GP within 12 months (Luoma et al, 2002)
- 45% (range 20-76%) within 1 month
- In England, 91% had at least 1 consultation (median=7) within 12 months (Pearson et al, 2009)
- In Scotland, 53% health service contact within 1 month (Stark et al, 2012)
- Rural dwellers less contact with mental health services

Management of depression

<33% with a diagnosable disorder seek professional help

Fewer than 40% of cases are diagnosed at primary care level

Of these, fewer than 40% are treated

only 30-40% take the medication as prescribed

Effectiveness of health systems in managing depression is 6%

Primary care and suicide prevention

- High level of contact with primary care in the 12 months before suicide
- Suicide relatively rare event in primary care practice.
- Risk factors for suicide are well-known but lack specificity
- GP reticence
- Lack of GP training for MH problems

Understanding Suicide _ Aims and objectives

- To identify barriers to suicide prevention
- To examine health service contacts of people who died by suicide over a two year period.
- To examine help-seeking from the perspective of family and friends.
- To explore the experiences and needs of GPs in caring for people who have died by suicide.
- To assess the impact of suicide on people bereaved by suicide by exploring coping strategies and the provision (and uptake) of support services for the bereaved.

Help-seeking in the context of suicide in Northern Ireland

Coroners Office data and GP records 1st March 2007-28th February 2009

In-depth individual interviews with 72 Family members bereaved by suicide

In-depth individual interviews with 20 GPs

Clinical data from GP records

- History of emotional or psychiatric problems (diagnosis, duration, treatment)
- *International Classification of Primary Care (ICPC-2)*
- History of physical long-term conditions (duration, treatment)
- All contacts with GP and recorded outcome 12 months before suicide
- Contact with other services including psychiatric referrals

Coroners Office data and GP records
findings

Coroners Office data and GP records
findings

- 401 eligible cases – 363 GP records (38 missing 9%)
- Overall suicide rate -11.3 per 100,000 population
- Age 11-83 years (Mean 39, S.D. 16.2)
- 81% males
- 31% Lived alone

Table 1. Suicide in Northern Ireland (March 2007-February 2009): crude rates* per 100,000 of the population - by gender and settlement type

	Males Rate (and Number)	Females Rate (and Number)	Persons Rate (and Number)
Urban	20.4 (130)	4.5 (31)	12.0 (161)
Large towns	23.2 (103)	6.6 (26)	14.1 (129)
Smaller towns	14.3 (21)	4.1 (7)	9.4 (28)
Rural	13.6 (69)	2.8 (14)	8.3 (83)
Total	18.5 (323)	4.3 (78)	11.3 (401)

*: **mid-year population estimates by settlement band (locale) for 2008 NISRA (used with permission).**

Mental health diagnosis

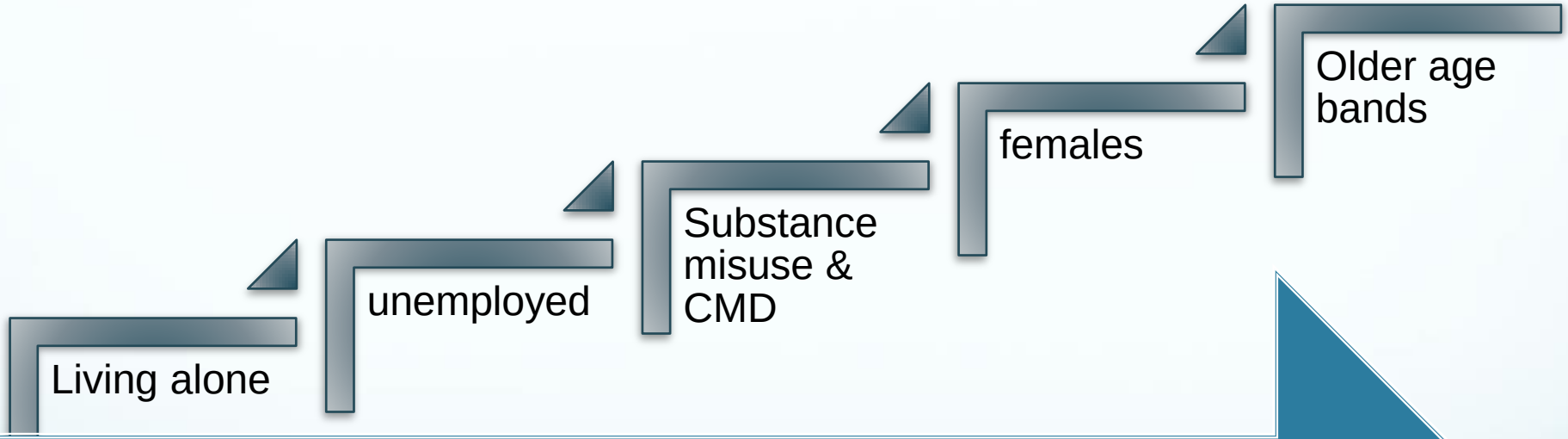
- 41% no recorded psychiatric diagnosis
- 33% common mental disorder
- 12% Severe mental illness
- 14% substance misuse

Factors associated with MH diagnosis

- Older patients 35+ years (OR=4.57, CI=2.61- 8.0)
- Living alone (OR=1.91, CI=1.08-3.40)
- Unemployed (OR=3.27, CI=1.64-6.53)

% of people in contact with GP prior to suicide

Factors associated with Likelihood and frequency of GP contacts – 12 months



- Particularly: women in larger towns, aged 35-54 years and living alone
- 57% - 80% over 12 months for mental health problems

Health and social care contacts – 12 months

- 41% had contact with accident and emergency services (58% relating to a mental health crisis)
- 18% had contact with a social worker (92% for mental health support)
- 35% saw a psychiatrist
- 29% supported by Community Mental Health Teams (CMHTs)
- 38.5% (n=155) prescribed antidepressant medications (9.2% of these had no mental health diagnosis)
- 2% in receipt of counseling services
- Considerable contact with nursing services but only 7% for MHP

Mean number GP consultations – mental health

	Male	Female
Consultations	5.75 (5.38, 6.15)	8.68 (7.85, 9.57)
Age*[1]*: <35 35-54 55+	5.17 (4.57, 5.83) 5.64 (5.10, 6.21) 7.23 (6.23, 8.34)	3.90 (2.77, 5.33) 10.90 (9.64, 12.17) 7.60 (5.99, 9.51)
Living alone[1]: no Yes	5.10 (4.66, 5.57) 6.94 (6.25, 7.69)	8.39 (7.43, 9.44) 9.36 (7.82,11.10)
Paid work[1]**:** yes No	6.35 (4.66, 5.57) 5.42 (4.96, 5.90)	8.25 (7.28, 9.30) 9.60 (8.10, 11.30)
Social class[2]**:** **Professional** Intermediate, semi-routine/routine Other	 7.0 (1.68, 19.93) 2.0 (2.0, 3.0) 4.0 (3.0, 6.0)	 5.0 (1.0, 10.0) 6.0 (1.0, 11.15) 6.5 (4.0, 11.0)
Locale type[1]**:** urban Larger town Small towns & rural - combined	5.05 (4.50, 5.65) 7.00 (6.29, 7.77) 5.25 (4.65, 6.01)	6.63 (5.42, 8.01) 12.59 (10.96, 14.39) 6.28 (5.04, 7.74)
Prior suicide attempts[1]: no Yes	5.79 (5.22, 6.40) 5.73 (5.23, 6.26)	8.08 (6.60, 9.78) 8.91 (7.93, 9.97)
Prior diagnosis*[2]*: none Common metal disorders Serious mental illness Alcohol/drugs	2.0 (1.0, 6, 3) 4.0 (3.0, 5.4) 3.0 (2.0, 4.5) 6.0 (4.0, 8.0)	3.0 (1.0, 21.0) 6.0 (3.0, 9.0) 6.5 (1.68, 19.2) 10 (1.0, 11.0)

factors related to General Practitioner *vigilance* to suicidality.

GP consultations: number[£]	1.18 (1.10, 1.27)***	1.18 (1.07, 1.31)**
age: 35-54 *(ref=< 35)* 55+	3.31 (1.61, 6.79)*** 2.11 (0.86, 5.20)	1.20 (0.47, 3.11) 0.52 (0.13, 2.15)
Gender: female *(ref=male)*	0.50 (0.18, 1.38)	0.18 (0.04, 0.81)*
MH problems: *(ref=none)* Common MH problems Serious mental illness Drugs/alcohol problems	 5.24 (2.36, 11.62)*** 11.08 (3.39, 36.20)*** 10.15 (3.45, 29.88)***	 3.47 (1.25, 9.66)* 8.08 (1.94, 33.71)** 4.28 (1.13, 16.25)*
Lives alone: yes *(ref=no)*	1.35 (0.67, 2.68)	0.74 (0.28, 1.95)
In paid work: no *(ref=yes)*	0.87 (0.45, 1.65)	0.90 (0.37, 2.22)
Locale: large towns Small towns[$] Rural areas *(ref=urban)*	1.99 (0.94, 4.22) na 1.65 (0.74, 3.65)	2.35 (0.93, 5.60) na 1.65 (0.60, 4.56)

In-depth individual interviews with 72 Family members and friends bereaved by suicide

In-depth individual interviews with 72 Family members bereaved by suicide

Kinship (n)	
Wife	19
Mother	11
Sister	11
Friends/Other	7
Brother	7
Father	6
Husband	4
Son	4
Daughter	3
Total	72

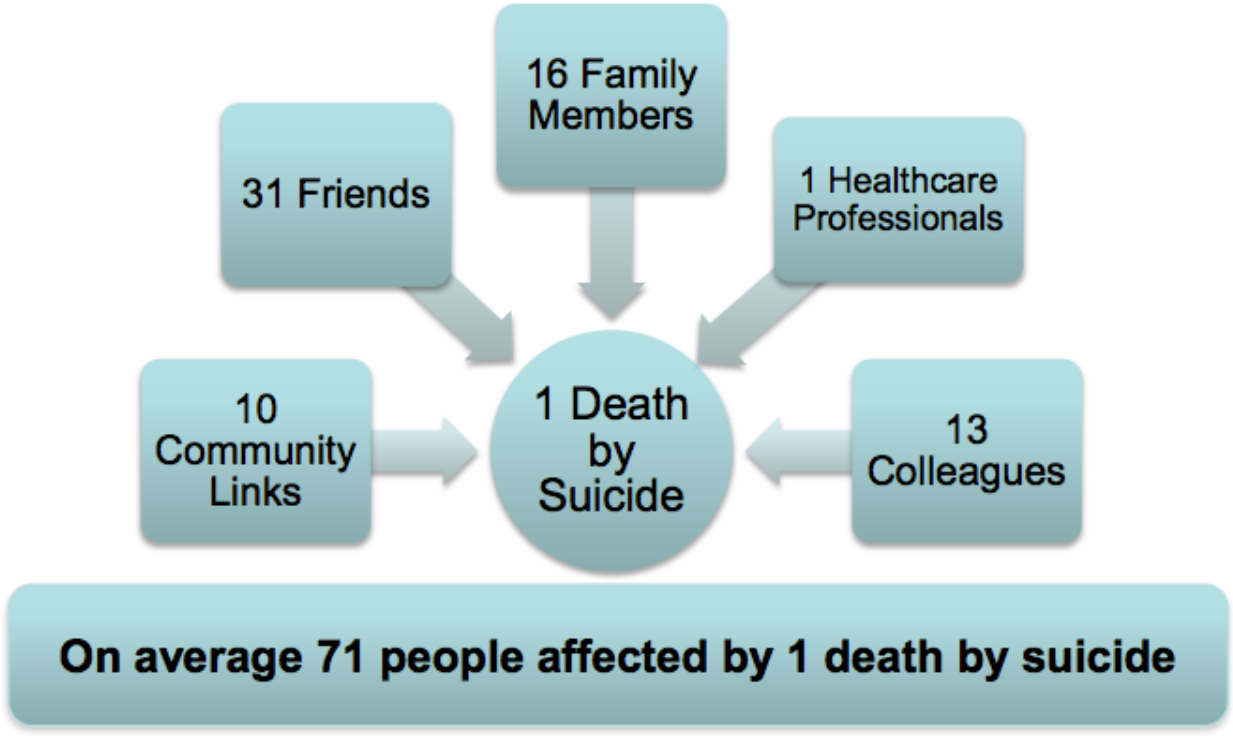
17 participants (24%) had been treated for anxiety and depression.

10 participants (14%) had described how they had contemplated suicide

9 others (13%) had attempted suicide

Impact of bereavement on the wider community

Number of people affected by a suicide
Next of kin perspective (n=43)



Family perspectives: barriers to care

Patient factors

- Hidden psychological problems
- Patient (and family) Stigma
- Negative perceptions of psychiatric units
- Family inability to cope (knowledge and skills)

Service factors

- GP misdiagnosis or minimisation
- Limited treatment options –
- Over-reliance on medication
- No review of medication
- Patient rejection of psychological therapies
- Fragmentation of care – poor follow-up
- Exclusion of family – communication/decision-making

It was different people we were seeing every day, … I could see that was a problem at the time, you know, because new people were coming all the time, they were introducing themselves, and, you know, he had to go through the whole thing with them again. That used to irritate him, you know
(P74, Wife).

In-depth individual interviews with 20 GPs

GP perspectives: barriers to care

Patient-related

- Rejection of diagnosis
- Medication non-adherence
- Substance misuse
- Multiple contacts
- Family

GP- Psychiatry related

- Long waiting lists
- Psychiatric focus on severe mental illness
- Inadequate follow-up
- Functional split model
- Fragmentation and bureaucracy
- No direct GP-Psychiatry contact
- Loss of shared knowledge and expertise

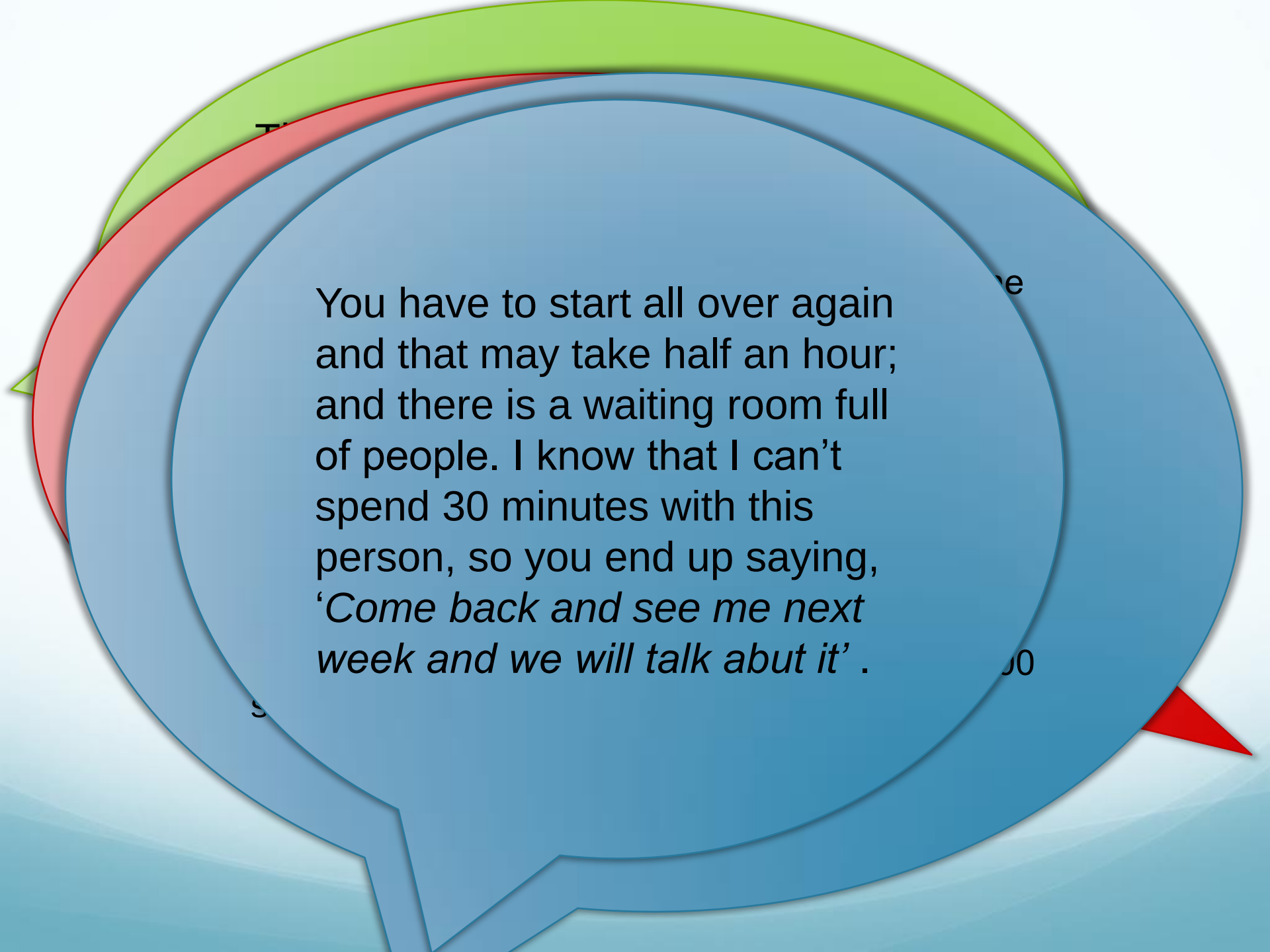
GP recognition

Patient

- Stigma and denial
- Somatic presentations
- Limited contact
- No prior history of MHP

GP factors

- Limited training
- Suicide as unpredictable
- Scepticism of patient suicidality
- Stereotyping (Belief in patient stoicism)


You have to start all over again and that may take half an hour; and there is a waiting room full of people. I know that I can't spend 30 minutes with this person, so you end up saying, '*Come back and see me next week and we will talk abut it*' .

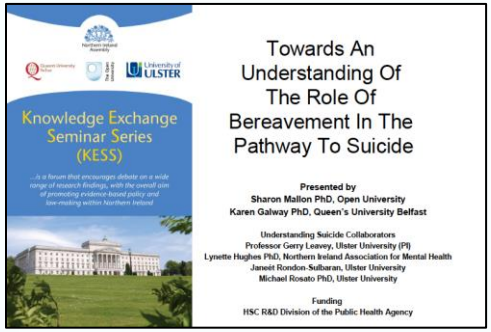
Summary

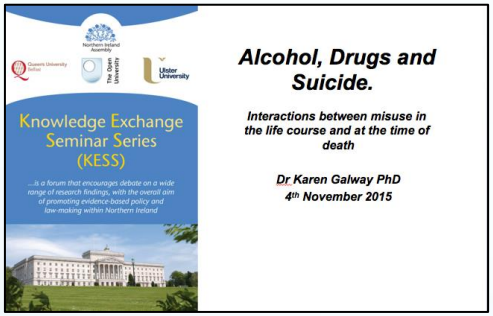
- No significant differences in urban- rural suicide rates – but raised in larger towns
- High levels of primary care contact
- Low recognition of mental health problems
- Considerable stigma-related problems
- Family exclusion from care planning
- Pressure on primary care
- Range of systemic disconnections

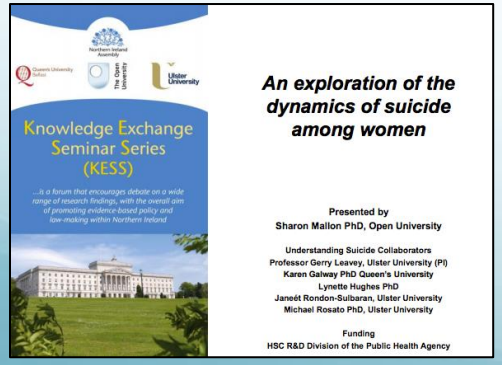
Conclusions and Recommendations

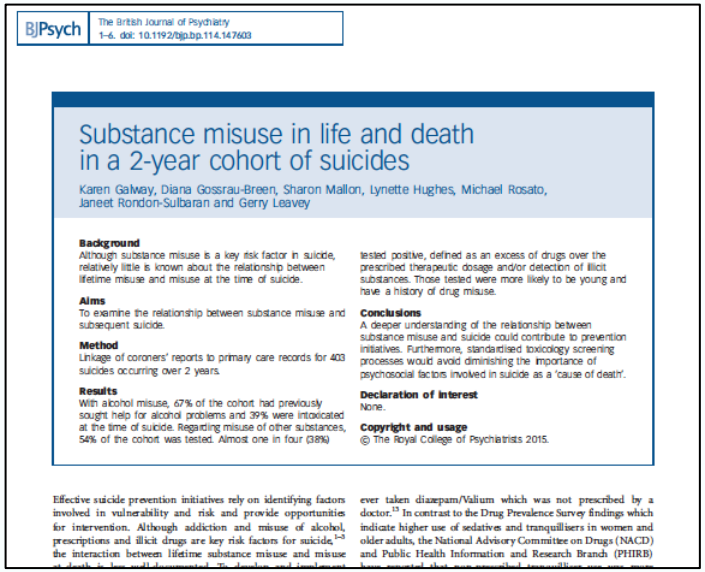
- Families as partners
- Review Protocols on confidentiality and Mental capacity
- GP training on mental illness
- Investment in integrated mental health care
- Targeted strategies on stigma of mental illness

Dissemination outputs









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Substance misuse in life and death in a 2-year cohort of suicides

Karen Galway, Diana Gossrau-Breen, Sharon Mallon, Lynette Hughes, Michael Rosato, Janeet Rondon-Sulbaran and Gerry Leavey

Background
Although substance misuse is a key risk factor in suicide, relatively little is known about the relationship between lifetime misuse and misuse at the time of suicide.

Aims
To examine the relationship between substance misuse and subsequent suicide.

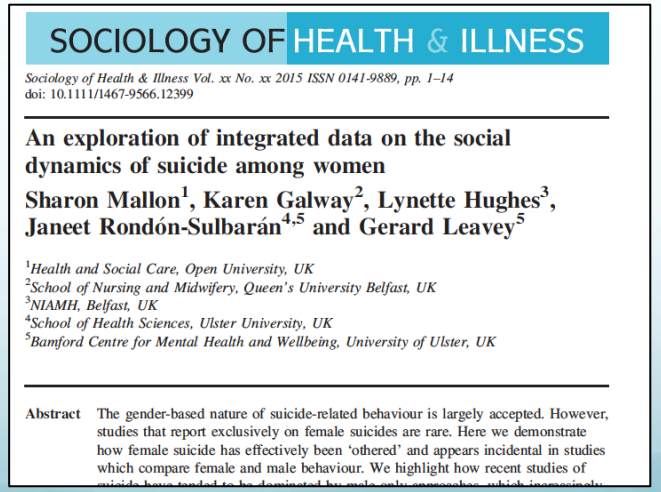
Method
Linkage of coroners' reports to primary care records for 403 suicides occurring over 2 years.

Results
With alcohol misuse, 67% of the cohort had previously sought help for alcohol problems and 39% were intoxicated at the time of suicide. Regarding misuse of other substances, 54% of the cohort was tested. Almost one in four (38%) tested positive, defined as an excess of drugs over the prescribed therapeutic dosage and/or detection of illicit substances. Those tested were more likely to be young and have a history of drug misuse.

Conclusions
A deeper understanding of the relationship between substance misuse and suicide could contribute to prevention initiatives. Furthermore, standardised toxicology screening processes would avoid diminishing the importance of psychosocial factors involved in suicide as a 'cause of death'.

Declaration of interest
None.

Effective suicide prevention initiatives rely on identifying factors involved in vulnerability and risk and provide opportunities for intervention. Although addiction and misuse of alcohol, prescriptions and illicit drugs are key risk factors for suicide,[1–3] the interaction between lifetime substance misuse and misuse ever taken diazepam/Valium which was not prescribed by a doctor.[13] In contrast to the Drug Prevalence Survey findings which indicate higher use of sedatives and tranquillisers in women and older adults, the National Advisory Committee on Drugs (NACD) and Public Health Information and Research Branch (PHIRB)



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An exploration of integrated data on the social dynamics of suicide among women

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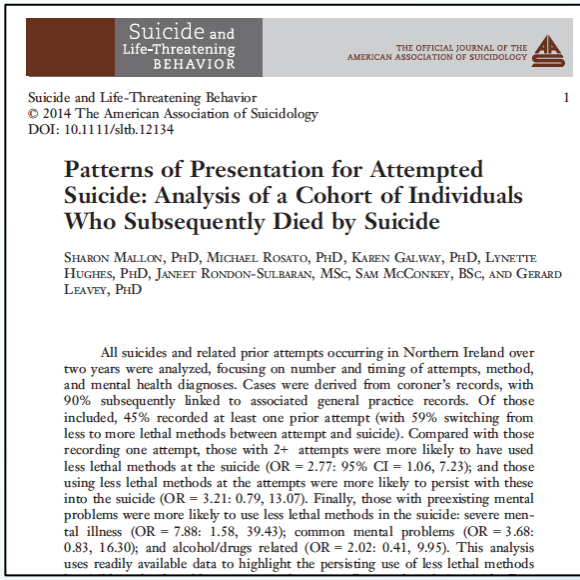
Abstract The gender-based nature of suicide-related behaviour is largely accepted. However, studies that report exclusively on female suicides are rare. Here we demonstrate how female suicide has effectively been 'othered' and appears incidental in studies which compare female and male behaviour. We highlight how recent studies of



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Suicide and Life-Threatening Behavior

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Patterns of Presentation for Attempted Suicide: Analysis of a Cohort of Individuals Who Subsequently Died by Suicide

Sharon Mallon, PhD, Michael Rosato, PhD, Karen Galway, PhD, Lynette Hughes, PhD, Janeet Rondon-Sulbaran, MSc, Sam McConkey, BSc, and Gerard Leavey, PhD

All suicides and related prior attempts occurring in Northern Ireland over two years were analyzed, focusing on number and timing of attempts, method, and mental health diagnoses. Cases were derived from coroner's records, with 90% subsequently linked to associated general practice records. Of those included, 45% recorded at least one prior attempt (with 59% switching from less to more lethal methods between attempt and suicide). Compared with those recording one attempt, those with 2+ attempts were more likely to have used less lethal methods at the suicide (OR = 2.77: 95% CI = 1.06, 7.23); and those using less lethal methods at the attempts were more likely to persist with these into the suicide (OR = 3.21: 0.79, 13.07). Finally, those with preexisting mental problems were more likely to use less lethal methods in the suicide: severe mental illness (OR = 7.88: 1.58, 39.43); common mental problems (OR = 3.68: 0.83, 16.30); and alcohol/drugs related (OR = 2.02: 0.41, 9.95). This analysis uses readily available data to highlight the persisting use of less lethal methods

Thank you

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