Written Evidence from Professor Navneet Kapur (SPR0178)

Meeting with the National Suicide Prevention Strategy Advisory Group

Many thanks for meeting with us on the 1st February 2017. The focus on implementation in the interim Health Committee report is really welcome.

It was suggested that I write to you in order to briefly highlight two issues that were discussed.

1 Data

The interim report focusses quite heavily on the determination of suicide deaths. Ascertainment is clearly an important issue which must not be ignored. Although deaths which have resulted in open conclusions are included in national statistics, there are ongoing concerns about narrative conclusions which I share. However, like others, I was keen that this did not side-track us from the policy, service-level, and clinical interventions that we could introduce to prevent suicide.

A separate data issue is that there are a number of other data sources in acute care[1], mental health[2], primary care[3], and across settings[4] that are increasingly being 'linked' with each other and with national mortality databases. This should enable health services and researchers to track people through the health care system, examine the care people receive, and determine who is most at risk from suicide. This is really about making better use of the data we already have to inform high quality care and prevent suicide.

2 Self-harm

We talked in the meeting about focussing on the 'big ticket' items - targeting areas where we might have most impact. One of the most important issues in suicide prevention is self-harm. It is a major cause of suicide with around half of people who die by suicide having a past history of self-harm. In the year after a person presents to hospital with self-poisoning or self-injury their risk of suicide is increased by 30-50 times[5].

Yet hospital services for self-harm are patchy and highly variable. NICE guidelines for many years have stressed the importance of a good quality assessment following self-harm. But still there is a fourfold variation in rates of assessment, with as few as 1 in 5 people receiving an assessment in some hospitals[6]. Overall only 6/10 people receive the assessment that national guidance and most clinicians agree they need[6]. This is not simply a resource issue but a consequence of how services are organized and prioritized. It also perhaps an indication of how people who harm themselves are sometimes viewed within health services.

Please do not hesitate to contact me if I can be of any further assistance.

[1]Hospital Episode Statistics, Emergency Care Data Set
[2]Mental Health Services Dataset, National Confidential Inquiry into Suicide, Multi-Centre Study of Self-Harm
[3]Clinical Practice Research Datalink
[4]Clinical Record Interactive Search System

[5] Cooper et al https://www.ncbi.nlm.nih.gov/pubmed/15677594
[6] Cooper et al http://bmjopen.bmj.com/content/3/11/e003444.full

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