Scottish Needs Assessment Programme

Suicidal Behaviour among Young Adults (15-34 years)

Summary Progress Report

SCOTTISH FORUM FOR PUBLIC HEALTH MEDICINE

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Priority Services Network

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1 Background

1.1 Although the government's policy statement, *Scotland's Health: A Challenge To Us All,*[1] does not identify mental health or suicidal behaviour as priority areas for action in Scotland, "the rising number of deaths from suicide in young men is a particular cause for concern" (Appendix A, para. 22, p.33).

1.2 In 1995 (the latest year for which data are available) there were 471 recorded suicide deaths in Scotland among males aged 15+ years (a rate of 23.5 per 100,000) and 147 suicide deaths among females aged 15+ years (6.9 per 100,000). Table 1 (Appendix 1) examines age-sex suicide trends between 1971-73 and 1993-95. Over this period the suicide rate among males aged 15+ years rose by 81%, with above average increases in the 15-24 age group (+169%), the 25-34 age group (+178%) and the 35-44 age group (+131%). Over the same time period the suicide rate among females aged 15+ years actually fell by 19%. However, increases were recorded in the 15-24 age group (+133%, albeit from a very low base) and the 25-34 age group (+43%). In both sexes the peak age for suicide has fallen dramatically over the past two decades: whereas 65-74 year old males and 55-64 year old females were most at risk in 1970-72, the 25-44 age groups (both sexes) were most at risk in 1993-95. These same trends have been noted in other European countries but are particularly marked in Scotland.

1.3 While national (Scottish) and regional data on suicide and undetermined deaths (the majority of which are probably hidden suicides) are collected and disseminated by the General Register Office, no comparable data have been published on the incidence or characteristics of parasuicide (whether by self-poisoning, self-injury or other method). SMR1 data are being used (or under consideration) by some health boards to provide proxy indicators of "attempted suicide", but the reliability and validity of this information have yet to be assessed. In any case, hospital-treated patients form only part of the total parasuicide population (many of whom are treated solely by the general practitioner or receive no medical treatment at all). In order to assess the need for services or other types of intervention, a broad survey of the extent of parasuicide in the community, the personal and social characteristics of the parasuicide population, and the precipitating and predisposing factors in parasuicidal behaviour would have to be undertaken.

1.4 The only research centre in Scotland devoted to the intensive study of suicidal behaviour (MRC unit for epidemiological studies in psychiatry) closed down in 1990. This unit monitored trends in hospital-treated parasuicide in Edinburgh but did not collect information from elsewhere in Scotland. In 1989 (the latest year for which reliable data are available) the rate of parasuicide in Edinburgh among males aged 15+ years was 282 per 100,000, with the highest rates among those aged 15-19 years (462 per 100,000), 20-24 years (453 per 100,000) and 25-34 years (477 per 100,000). Among females aged 15+ years in the city in the same year the parasuicide rate was 315 per 100,000, with the highest rate in the 15-19 age group (838 per 100,000), rates thereafter declining with age. This level of parasuicide incidence, though very high in comparison with that reported for other European cities,[2] was lower than the peak rates recorded in the 1976/77. (In 1976 the overall parasuicide rate among male Edinburgh residents aged 15+ years peaked at 340 per 100,000. Among 15-19 year old males the rate was 401, among 20-24 year old males, 1008 and among 25-34 year old males, 484. In 1977 the rate among female residents in Edinburgh aged 15+ years peaked at 461 per 100,000. The rates among females aged 15-19 years, 20-24 years and 25-34 years were 1075, 1063 and 700, respectively.) However, monitoring of parasuicide admissions to the Royal Infirmary in Edinburgh during the 1990s suggests that the behaviour may once again be reaching epidemic levels.

1.5 ‘Suicidal behaviour ... is embedded in a complex web of behavioural, emotional, interpersonal and social factors that have to be attended to concurrently at the individual, family and social level’.[4] While evidence of the aetiological significance of psychiatric illness in completed suicide is beyond doubt[5,6] (although this is not the case in respect of parasuicide[7]), macro-economic[8] and other structural factors (eg poverty/social deprivation[9]) and cultural influences (eg mass media[10]) have also been shown to be extremely powerful.

1.6 Consequently, the problem of suicidal behaviour is best conceptualised within a public health framework. Primary prevention depends above all on the capacity of the state to create optimal conditions for healthy lifestyles and reduce the risk of self-harmful behaviour. Possible measures which could reverse the rising trend of suicidal behaviour, with special reference to youth and young adults, include:

- reducing the availability of means of self-harm, especially poisons and medicaments which are dangerous in overdose;
- implementing effective measures to tackle drug and alcohol abuse;
- controlling and reversing the growth of unemployment, especially long-term, and increasing the level of economic activity;
- providing an adequate financial and welfare safety-net for the whole population;
- combating physical disintegration and social disorganisation in inner-city areas;
- reducing social isolation and exclusion, particularly in rural areas;
- seeking to alter public attitudes which increase the vulnerability of high-risk groups (eg victimisation and stigmatisation of the unemployed and mentally ill).[11, 12]

1.7 A recent review[13,14] of the literature on the effectiveness of interventions aimed at preventing suicide concludes that “there is no firm evidence that specific health service interventions are capable of preventing suicide .... It may be ... that it is processes occurring at the level of society, levels of integration and social values that are responsible for current [upward] trends [among men] and thus reversal will need fundamental changes at a governmental social policy level.” Primary prevention of parasuicide also remains a difficult challenge, while interventions designed to prevent further episodes of parasuicide (secondary prevention) have failed to demonstrate a significant effect.[15]

2 Remit for further work

2.1 Literature/information search covering:

- incidence of, and temporal trends in, suicidal behaviour (suicide and parasuicide) among young adults across Scotland (at national and health board levels)

- availability and quality of SMR1 date as proxy indicator of hospital-treated parasuicide

- a review of literature on suicidal behaviour among young adults (in Scotland)

- local health service and social work strategies for containing/reversing trends in suicidal behaviour among young adults in Scotland

- service demand and service provision for suicidal young adults

- extent and timescale of research on suicidal behaviour among young adults in Scotland (funded by research councils, Scottish Office, health boards, etc).

2.2 Design a methodology for establishing:

- the true (total population) incidence of suicidal behaviour at local (health board) and national levels

- the extent and quality of service provision for suicidal individuals across Scottish health boards, including specification and measurement of agreed standards and outcomes.

2.3 Monitor and collate opinions and attitudes of commissioners, providers, academics, users and other relevant individuals/organisations about key issues relating to suicidal behaviour, in particular:

- extent of the problem

- adequacy of local service provision

- actual and potential role of health education/promotion at both local and national levels in reducing the incidence of suicidal behaviour.

2.4 Make recommendations to appropriate organisations/bodies, including:

- health boards

- provider units/trusts/primary health care teams

- social work services

- research funding bodies

- Scottish Office Department of Health

- Health Education Board for Scotland.

3 Progress to date

3.1 Data have been collated on trends in parasuicide by sex and age group, across Scotland (as a whole and by health board area), over the period 1984-93. As Table 2 (Appendix 1) shows, an increase in parasuicide has occurred in both sexes, but more markedly among men, with the result that the ratio of female: male parasuicide has been greatly reduced. For instance, whereas in 1984 the parasuicide rate among men and women aged 16+ years was 209 and 252, respectively, the rates in 1993 were 305 and 313, respectively. This trend towards convergence of male: female parasuicide rates has also been noted in other European countries[16] Variation in both suicide and parasuicide rates across health board areas is evident (see Table 3, Appendix 1).. The highest parasuicide rate appears to be in Lothian (1993 rates were 375 per 100,000 male residents aged 16+ years; and 410 per 100,000 female residents aged 16+ years); by contrast, the highest suicide rate is found in the Highland region.[17]

3.2 These parasuicide data are based on SMR1 returns, with the operational definition that of discharge from hospital following inpatient admission resulting from deliberate self-inflicted injury or poisoning. Assessment of the validity and reliability of the data continues. While preliminary evidence suggests that there is an acceptably high level of accuracy and consistency in the information obtained from larger hospitals, the quality of data from small hospitals is more doubtful. This source of information does, however, omit entirely cases of parasuicide which are treated solely in Accident and Emergency Departments, or by primary care or community mental health services, or receive no treatment at all.

3.3 An enquiry has been sent to local Health Boards and Social Work Departments in order to ascertain whether the problem of suicidal behaviour has been addressed at a strategic level. Information has been received from 14 (out of 15) Health Boards and 9 (out of 12) Social Work Departments. Analysis is ongoing but preliminary assessment reveals a range of responses from Health Boards to questions about the setting of specific targets for health gain related to suicidal behaviour; the actual and potential role envisaged for health promotion in reducing the incidence of suicidal behaviour; and the nature of services or quality standards relating to the care and treatment of suicidal individuals, as specified in contracts with providers.

3.4 The Lothian Users Forum has conducted a survey of attitudes towards services for parasuicide among a small sample of users. The overall level of satisfaction with treatment and care offered to respondents was very low, and many suggestions were made for improvements in the quality of the service and training of staff.

4 References

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Table 1
Change in suicide rate, by age and sex: Scotland 1971-73 to 1993-95

	Suicide rate/100,000		Change (%)
	1971-73	**1993-95**	**Change (%)**
Males			
15-24 years	7.8	21.0	+169%
25-34 years	10.2	28.4	+178%
35-44 years	12.8	29.6	+131%
45-54 years	15.5	25.3	+63%
55-64 years	16.8	19.5	+16%
65-74 years	19.2	13.5	-30%
75+ years	14.2	14.7	+81%
All 15+ years	13.0	23.5	
Females			
15-24 years	1.8	4.2	+133%
25-34 years	5.8	8.3	+43%
35-44 years	8.4	8.3	-1%
45-54 years	10.8	8.2	-24%
55-64 years	15.8	6.6	-58%
65-74 years	9.7	5.6	-42%
75+ years	8.8	6.4	-27%
All 15+ years	8.5	6.9	-19%