Mental Illness and Suicide Prevention: Wolverhampton Needs Assessment 2015

A collaborative project between Wolverhampton City Council Public Health and Wellbeing Team and Wolverhampton Samaritans

Sarah Wilkinson [1], Foundation Year 2 Doctor in Public Health

July 2015

[1] *Contact for enquiries:* Neeraj.Malhotra@wolverhampton.gov.uk

Acknowledgements

I would like to thank all those who have supported me with this work. Firstly, Dave Martin (Samaritans), Neeraj Malhotra (Public Health) and Sue Wardle (Public Health) for their guidance and opinions while undertaking and producing this project. I would also like to thank Karla Bailey (Public Health) for her data contribution. Importantly, I wish to thank the 20 organisations who kindly agreed to meet with me, as well as those who completed, or aided the distribution of, the primary care survey. Finally, I would like to thank all those who have commented on the report and who have stimulated ideas around the issues.

Executive Summary

This needs assessment is a collaborative project between the Wolverhampton Public Health Department and the Wolverhampton Samaritans, and has been based on consultation with local stakeholders working with the wider determinants of mental health. It profiles those adults at high risk of developing mental health disorders, with a particular emphasis on suicide; and maps which services are available to support these high risk groups in Wolverhampton. This will guide focussed outreach by the Wolverhampton Samaritans, inform local commissioning and highlight future areas for study.

Mental, emotional and psychological problems account for more disability than all physical health problems combined in the UK; and mental health problems are estimated to cost £105 billion annually in England. Suicide is the leading cause of death for 20-34 year olds in the UK and each completed suicide during working age costs £1.67 million in England.

90% of people who commit suicide had evidence of a mental illness prior to their death, but only 29.5% had been in contact with secondary statutory mental health services in the preceding 12 months. To reduce suicide at a population level, there should be both suicide-specific interventions and general measures to improve population mental wellbeing and engagement with services, with a view to helping the 60% who go on to complete suicide without being known to formal services.

Key Findings

Suicide is four times more common in men than women and this gap is widening nationally. The highest rates of suicide are in those aged 30 to 59 years – it has been high in the 30 to 44 age group for many years, but there is an upward trend in the 45 to 59 age group that doesn't yet show signs of plateauing. Ethnicity data is not formally collected by coroners. Globally, suicide rates are highest in Eastern Europe, and many Wolverhampton migrants originate from this area. Non-heterosexual sexual orientation is also a risk factor for suicide, with the greatest risk being in homosexual men.

Areas of deprivation are associated with increased suicide rates, and over half of Wolverhampton residents are in the most deprived 20% of the country. The recent recession may exacerbate this. Homelessness is higher in Wolverhampton than nationally, and multiplies the risk of suicide by nine.

Isolation increases the risk of suicide, whereas marriage confers protection against suicide. The risk of suicide is increased by bereavement – especially when a male partner loses their spouse. The risk of suicide in men is four times greater when their partner dies by suicide than by any other cause.

Risk of suicide risk increases with depression severity, and in Wolverhampton the incidence and prevalence of depression is higher than nationally. Mood disorder is the most common psychiatric diagnosis in inpatient suicide. Wolverhampton has a higher alcohol related hospital admission rate than nationally, and heavy drinking confers a three-fold increase in suicide risk. Physical illness also raises suicide risk, particularly in terminal and chronic conditions.

Local stakeholders were consulted through interviews with local organisation working with the wider determinants of mental health and through an online survey distributed to local primary care. This consultation showed that migrants, men and deprived communities were thought to be at the greatest risk of mental health problems locally. In contrast, women are more likely to approach their

GP for mental health support. The most commonly reported triggers for mental health crisis were (1) relationships, (2) employment, (3) housing and (4) drugs/alcohol.

The most common concerns with mental health support provision in Wolverhampton currently are (1) waiting times, (2) needing to be referred via GPs, (3) the system being too complicated (particularly with regards to dual diagnosis patients) and (4) language barriers. Waiting times were mentioned by more than 60% of community groups. Although the referral rate is lower for Wolverhampton IAPT than the national average, the waiting times are longer. Although almost half of stakeholders reported needing to be referred by a GP as a barrier to access, Healthy Minds introduced self-referral in late May during the writing of this project.

The greatest supply of services locally is for women and the Asian community. This is in contrast to the areas of need identified by both data and stakeholder consultation. Therefore, the biggest gaps in provision are for men and for migrants. When considering geography, there is a paucity of mental wellbeing support in Bilston, and a lack of third sector mental health support in Whitmore Reans (both of which being highly deprived areas and therefore likely in great need of support).

Key Recommendations

These recommendations have been formulated based on the findings of the report as well as comments from the confirm and challenge workshop of key local mental health stakeholders.

- The mental health service directory should be redesigned to become more easily accessible and to facilitate it being kept up-to-date. It should be well-advertised to the local population.
- Access to low-tier statutory services should not be limited to referral via GPs alone.
  NB. This is currently being superseded by self-referrals for Healthy Minds
- Ways to limit mental health deterioration while awaiting treatment should be explored and the Healthy Minds waiting lists should be monitored during the transition to self-referrals.
- Frontline staff, in health and non health occupations, for example the police, fire and rescue, and those who come into contact with people who are homeless, unemployed, on benefits, socially isolated or otherwise vulnerable should be confident and competent in recognising signs of mental distress and how to support people appropriately and know where to refer onwards if necessary.
- The need for similar training in the voluntary sector should be assessed, especially amongst those groups providing practical support in those areas and with groups that are at higher risk. Training for frontline staff and others can be provided by the Samaritans, or, if focussing on young adults, by Papyrus. Training packages includes ASSIST, Mental Health First Aid, and STORM.
- How to provide more joined-up support for dual diagnosis patients should be considered.
- Men should be encouraged to engage with mental health support and the provision of male-specific services should be increased.
- More should be done to support the mental health of the migrant community.
- Future commissioning should address geographic imbalances – there is a sparsity of mental wellbeing services in Bilston and of third sector mental health support in Whitmore Reans.
- Local communications teams should ensure that when reporting cases of suicide, local media have access to appropriate guidelines, for example, those produced by the Samaritans, and should work with their media contacts should an incident occur.

- Local authority planning teams should consider suicide prevention by ensuring that new developments and plans do not increase access to the means of suicide and also by designing and maintaining suicide prevention signage. Local authorities could also consider working with other transport partners to identify ways to reduce means of suicide on the transport network. Examples include installation of barriers on bridges, erecting signs, and providing access to telephone hotlines.
- Local pharmacies should be engaged in campaigns, for example to support safe medicine management.
- A campaign to raise awareness of suicide prevention amongst the general public and promote suicide prevention guidance, for example by using MIND's 'supporting someone who feels suicidal' and raising awareness by supporting World Suicide Prevention Day should be considered.
- Wolverhampton organisations should consider signing up to campaigns that challenge mental health stigma, such as 'Time to Change'. http://www.time-to-change.org.uk/
- Workplaces should be encouraged to sign up to policies that support positive mental health, as outlined in NICE guidance 'promoting mental wellbeing at work' (NICE Guidance PH 22) http://www.mind.org.uk/information-support/types-of-mental-health-problems/suicide-supporting-someone-else/#.Vfl5GxFViko
- The emerging issue with new psychoactive substances ('legal highs') should be investigated.
- How best to manage data sharing appropriately between organisations should be investigated, in order to try to allow improved joined up working across the city.

> *"The best results for mental health promotion, mental illness prevention, and suicide prevention have been achieved by initiatives that […] address a combination of known risk and protective factors, set clear goals, support communities to take action, and are sustained over a long period of time."*
>
> Changing Directions, Changing Lives: The Mental Health Strategy for Canada (121)