Health and Wellbeing Board **23 November 2016**

Report of the Director of Public Health

Update on Suicide Prevention: City of York Suicide Audit – a review of deaths by suicide within the City of York between 2010 and 2014

Summary

1. The purpose of this report is to present the results of the audit of deaths by suicide as recorded by the York Coroner Service during 2010-2014. The audit was completed for the 60 people who died by suicide in York during this period for whom Coroner case files were available.

2. The audit was conducted in order to better understand suicide in York and to help inform the development of a local suicide prevention action plan which will support our aspiration for York to become a Suicide-Safer Community.

Background

3. Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This can only be done by working collaboratively across all sectors within York. Suicide causes much distress to the families and friends affected and this is one of the key areas for consideration in suicide prevention.

4. The numbers of suicides occurring within a timeframe or locality are usually calculated as a rate. Hence the suicide rate is based on how many people out of every 10,000 or 100,000 people in the population are recorded as having taken their own life or died through accident or poisoning of undetermined intent.

5. The suicide rate in York for 2013-2015 was 14 suicides per 100,000 of population and this is significantly higher than the national and regional rates (10.1 and 10.7 per 100,000 respectively).

6. In 2013-15 York had the highest suicide rate when compared to other local authority areas that have similar levels of deprivation. Deprivation has been used as a comparison because death by suicide is more common among people who live in deprived areas. In 2013, one of the peak years for suicides in York, the age adjusted suicide rate for males of working age (18-64) was the fourth highest in England.

7. Therefore it is important that we have an effective and evidence-based suicide prevention plan in place across the City to halt the continued rise in suicide deaths.

8. The All Party Parliamentary Group (APPG) on Suicide and Self-Harm published an 'Inquiry into Local Suicide Prevention Plans in England' in January 2015. The APPG considered that there were three main elements that are essential to the successful implementation of the national strategy for suicide prevention. All local authorities must have in place:

   - Suicide audit work to understand local suicide risk and identify any emerging trends

   - A suicide prevention plan in order to identify the initiatives required to address local suicide risk

   - A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

9. Under the Health and Social Care Act 2012, Public Health responsibilities transferred to the local authority. Suicide prevention is one of the indicators in the Public Health Outcomes Framework and so it falls under the strategic responsibility of the local authority Director of Public Health.

10. There is a North Yorkshire and York Suicide Prevention Task Group that has been in place for some time and this group has developed an action plan which is based on the six areas for action set out in the national strategy for suicide prevention. It is fair to say that the action plan has been mainly focused on North Yorkshire up to now and work has started on the development of a City of York suicide action plan which takes account of the particular issues for the City e.g. the needs of the student population.

11. The North Yorkshire and York Suicide Prevention Task Group has been led by the North Yorkshire Public Health Team since it was established. The Chair of the Task Group has recently been passed to the City of York Director of Public Health. Work is underway on a stock take of the group, review of membership and refresh of the action plan and this work will be completed over the next few months.

12. The decision to undertake separate suicide audits for North Yorkshire and York was based on this need to take account of the differences in geography and population and to identify any common themes that we could work collaboratively to address. However the two audits looked at deaths by suicide over the same time period, 2010-2014, and used almost identical methodologies. The geographical proximity that the two audits cover and the collaborative approaches to suicide prevention that partner agencies across both local authority boundary areas have, enabled shared learning and the consideration of joint approaches to reducing suicide in these areas.

Main/Key Issues to be Considered

13. The completion of a suicide audit is a key element of local suicide prevention work to help identify ways in which suicide rates might be reduced.

14. The suicide audit was led by the City Of York Council Public Health Team and reviewed all deaths by suicide as recorded by the York Coroner Service during 2010-2014. The audit was completed for the 60 people who died during this period for whom records were available but acknowledges that this did not allow the audit of files relating to all of the people who died by suicide during this time period. The audit team estimate that there were possibly an additional 13 people who died by suicide during this time but definitely an additional 10 people for whom case files were not available.

15. The objectives of the audit were to:

    - Compare local, regional and national data and trends

    - Identify local risk factors, groups at risk or localities of higher incidence

- Establish the extent and nature of contact with various services by those who subsequently completed suicide
- Provide an insight into common situations, stresses and triggers which led to suicide
- Inform future prevention strategies in conjunction with a review of the evidence base for them
- Provide a bench mark of evidence to inform future audits and evaluate prevention strategies
- Develop a sustainable system for future data collection
- Explore opportunities to intervene, provide support and address gaps in service in order to reduce or mitigate further risk

Key Findings

16. A summary of the key findings is presented below. The full suicide audit report can be found as an **Annex** to this report.

17. An audit template was used to record information that described the circumstances surrounding the death by suicide. Data and thematic analysis were carried out on this information which highlights that across the 60 people whose records were examined across this time period:

- The average age at death was 42.8 years
- An estimated 2,249 years of life were lost by suicide
- Approximately three quarters of people were single, divorced or separated. 44% lived alone
- Whilst suicide affects people from a full range of backgrounds there was a higher proportion of death by suicide amongst people living in more deprived areas.
- 48% had a physical or sensory health condition at time of death; 47% had a history of substance misuse; 40% had a history of self-harm; 37% had a diagnosed mental illness and 25% had previously attempted suicide.

- Hanging was the most common method of suicide; the majority of incidents took place in the person's own home; although seven incidents took place on the railway

- About half of the people left a suicide note

- 22 out of 60 people in the York sample (37%) had drunk alcohol prior to their death, 14 people were over the drink drive limit and seven of these were heavily intoxicated at the time of death

- For over half of the people who died, there were warning signs or evidence of poor risk prior to their suicide e.g. suicide intent, suicidal thoughts or significant behavioural change

- A thematic analysis identified the main themes linked to suicides to be:

    - History of self-harm / suicide attempts

    - Diagnosed mental health problems

    - Loneliness and isolation / lack of engagement

    - Undiagnosed mental ill health / emotional distress

    - Family / relationship problems

    - Substance misuse

- In the year prior to death, 63% had a recorded visit to their GP; 52% had taken up psychiatric treatment; 40% had contact with specialist mental health services and 28% had attended the Emergency Department at hospital

- 32% of the people had either declined some form of psychiatric treatment or shown a lack of adherence to their medication / treatment plan in the year prior to death

- Whilst 28 people had a history of substance misuse, only four had a treatment record in York, suggesting a possible lack of engagement with substance misuse services

- 13 people (22%) were City of York Council adult social care clients or current City of York Council housing tenants at the time of death

- 43 people had previous contact with the police as victims, persons reporting a crime, suspects, offenders, witnesses and subjects (e.g. concerns for safety or missing person). 37 of these had contact in the 12 months prior to their death.

- 51 out of 60 people (85%) had some recorded contact in the 12 months prior to their death with at least one agency or organisation, leaving nine people (15%) who had no recorded contact. The average age of the people who died but had no contact with services was 32.3 years which is younger than the average age of those who had been in contact with some agency – which was 44.6 years

18. There is an intention that the audit process will be completed again to review death by suicide over the period 2015-2019. In the interim period, City of York Council will continue to work collaboratively with key partner agencies to raise awareness about suicide risk and suicide prevention in order to reduce death by suicide.

Consultation

19. The purpose of the audit was to review the records of deaths by suicide over the period 2010-2014 made available to the audit team by the Coroner's Office.

20. A conference took place on 28 October 2016 hosted by the University of York and organised jointly by North Yorkshire Police and City of York Public Health. The conference focused on addressing some of the themes identified in the suicide audit around mental health and suicide prevention, including a theme on support for those affected by suicide through hearing the stories from those who have lived experience. The conference was very well supported with around 75 delegates participating.

Options

21. There are no options to consider. The report sets out the key findings from the City of York Suicide Audit and review of deaths by suicide within the City of York between 2010 and 2014.

Analysis

22. The suicide audit report makes a number of recommendations based on the findings of the audit. These are to:

- Achieve Suicide-Safer Community accreditation
- Develop a local suicide prevention strategy
- Ensure that recommendations contained in the National Confidential Inquiry into Suicide and Homicide by People with mental Illness (October 2016) are considered, implemented and embedded into the policies and practices of local commissioned mental health services.
- Implement a regular programme of suicide audits and use these to inform suicide prevention priorities and development needs
- Develop the local real-time suicide surveillance process to include consideration of people who may be at particular risk of suicide in order to improve responses designed to reduce suicide risk and prevent potential suicides from happening
- Provide more responsive support arrangements to those affected by the suicide of someone they knew.
- Raise awareness about the groups most at risk from suicide and the need to assess risk of suicide for people being supported by services
- Develop a communication approach for the city that includes raising awareness amongst those at most risk from suicide and that supports their friends and family to be able to act.

23. It is proposed that the North Yorkshire and York Suicide Prevention Task Group consider these recommendations when developing the joint strategic framework for suicide prevention across both local authority areas. The newly established post of Suicide Prevention Lead Officer for City of York will have responsibility for developing a local suicide prevention action plan that is bespoke for York.

24. One of the areas to be considered in due course is the availability of prompt support for people recently bereaved or otherwise affected by suicide. 'Postvention' is the term used for the practical and emotional support provided to people following the loss of a loved one or close acquaintance through suicide, or otherwise affected by such incidents. This is widely recognised as an important element of suicide prevention work because of the known direct risk to those who are bereaved and the need to

support people though a particularly traumatic period of their life. Some local authorities have bespoke postvention services directly linked to police/coroner referral processes and these have been high-lighted as national best practice.

Strategic / Operational Plans

25. The suicide audit findings will be valuable in informing our local approach to suicide prevention across the City of York and our vision to become a "Suicide-Safer Community".

Why become a Suicide-Safer Community?

26. The Suicide-Safer Communities designation honours communities that have implemented concerted, strategic approaches to suicide prevention. The nine pillars in this designation reflect the core elements of suicide prevention strategies around the world. The designation celebrates and acknowledges those communities who have made significant progress in reaching their suicide-safer goals, and helps others understand what strategic steps they can take to prevent suicide on a community level.

27. The work is co-ordinated around 9 pillars of action:

- Leadership/ Steering Committee
- Background Summary
- Suicide Prevention Awareness
- Mental Health and Wellness Promotion
- Training
- Suicide Intervention and Ongoing Clinical/Support Services
- Suicide Bereavement
- Evaluation Measures
- Capacity Building/ Sustainability

28. In order for a community to be designated a Suicide-Safer Community there is an accreditation process based on a review of documentation evidencing all 9 areas. Designation is for five years with a review at five years for re-designation.

29. Suicide-Safer Community designation is a public affirmation of, and testament to include community-wide safety from suicide as a priority contribution in creating a safer, healthier and hope-filled life for its citizens. In this way the work will support our aspirations for better mental health for our residents of all ages.

30. The Mental Health and Learning Disabilities Partnership Board received a discussion paper on Suicide-Safer Community at the meeting on 25 July 2016 and agreed to recommend that the Health and Wellbeing Board endorse a direction of travel for the City of York to achieve Suicide-Safer Community designation.

Council Plan

31. The proposal directly relates to the Council Plan 2015-19 priorities:

- **'A prosperous city for all'**
- '**A focus on frontline services'** - to ensure all residents, particularly the least advantaged, can access reliable services and community facilities.
- **'A Council that listens to residents'** – to ensure it delivers the services they want and works in partnership with local communities

Specialist Implications

Financial

32. At this point it is unclear what the direct cost implications to becoming a designated Suicide-Safer Community may be. There will be further work undertaken to understand the potential resource implications of the accreditation process. One of the foundations of accreditation, however, is the provision of suicide prevention training for operational staff and community members.

33. Living Works which designed the 'Suicide Safer' model promotes two of its suicide prevention courses which are delivered by accredited trainers working within various organisations. Relevant training is either the two day 'ASIST (Applied Suicide Prevention Skills Training) or the three hour 'Safetalk' courses. Both are designed to raise awareness of the issue of suicide and improve the confidence and communication skills of delegates when engaging with someone who may be contemplating suicide.

34. An initial programme for the delivery of Safetalk to operational staff in the city, funded by Public Health England is due to conclude in January. Hence only a relatively small proportion of staff in front line roles has been trained and to achieve accreditation it is essential that further training provides much more comprehensive coverage. There will therefore be financial implications to individual partners in supporting such training to ensure that employees are equipped with a key work and life skill. Costs are not yet quantifiable as they are dependant on the required extent of workforce coverage and the optimum ratio for delivery of the two courses.

35. Other work on suicide prevention can still be organised around the 9 pillars within existing resources since it provides a useful framework for co-ordinated community action.

Human Resources (HR)

36. There are no Human Resources implications from this report.

Equalities

37. There are no equalities implications from this report.

Legal

38. There are no legal implications from this report.

Crime and Disorder

39. There are no crime and disorder implications from this report.

Information Technology (IT)

40. There are no IT implications from this report.

Property

41. There are no property implications from this report.

Risk Management

42. There are no risks associated with this report.

Recommendations

43. The Health and Wellbeing Board is asked to:

- Receive the City of York Suicide Audit 2010-2014 report and approve its publication as one of the suite of documents supporting the Joint Strategic Needs Assessment for York

- Note the intention to repeat the audit process to review death by suicide in the City of York over the period 2015-2019.

- Support the recommendation from the suicide audit that the findings be used to inform a local suicide prevention action plan for the City and delegate this responsibility to the Chair of the North Yorkshire and York Suicide Prevention Task Group.

- Endorse the vision and direction of travel for the City of York to become a Suicide-Safer Community

- Agree to receive annual reports detailing progress on implementation of the local suicide prevention action plan and highlighting any key areas of concern

Reason: To support the work on suicide prevention and the vision for York to become a Suicide-Safer Community.

Contact Details

Author:

Nick Sinclair
Public Health Specialist
Practitioner Advanced
Nick.sinclair@york.gov.uk

Andy Chapman
Suicide Prevention Lead Officer
Andy.chapman@york.gov.uk

Chief Officer Responsible for the report:
Sharon Stoltz
Director of Public Health

Report Approved	√	**Date**	09/11/16

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers

National Suicide Prevention Strategy for England 2012

https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&sqi=2&ved=0ahUKEwj895Hnkd_OAhUkBMAKHTa3AS8QFggjMAA&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fsuicide-prevention-strategy-for-england&usg=AFQjCNF73slsz7KGPcBGz2QHvmw8yHQ9Ew&bvm=bv.130731782,d.d24

Public Health England. Guidance for developing a local suicide prevention action plan. September 2014.

https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

Public Health England. Identifying and responding to suicide clusters and contagion.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459303/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf

North Yorkshire Suicide Audit 2010-2014

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjUwZS5kd_OAhWlC8AKHRa-CHkQFggjMAA&url=http%3A%2F%2Fdemocracy.northyorks.gov.uk%2FFunctionsPage.aspx%3Fdsid%3D78094%26action%3DGetFileFromDB

&usg=AFQjCNFaTHHFS_5tcp1i_9Ot3f_n2XuEYg&bvm=bv.130731782,d.d24

Suicide- Safer Communities

https://www.livingworks.net/community/suicide-safer-communities/

Annex

City of York Suicide Audit – a review of deaths by suicide within the City of York between 2010 and 2014.